PILKINGTON

PILKINGTON NORTH AMERICA, INC.

POST- EMPLOYMENT HEALTH CARE SUMMARY PLAN DESCRIPTION

For Retirees and Surviving Spouses Represented by
UNITED STEELWORKERS of AMERICA, AFL-CIO, CLC

Effective April 1, 2003

PNA*Benefits*

A. INTRODUCTION TO YOUR HEALTH CARE BENEFITS

Pilkington North America is pleased to offer eligible retirees, surviving spouses and dependents high-quality, cost-effective health care benefits, including medical, mental health, and prescription drug components. In the following pages you will find information on the benefits available through each of the programs and how to use the benefits effectively.

EXPLANATION OF TERMS

Throughout this summary plan description, you will find words and terms CAPITALIZED or in *italics*. A further explanation of these capitalized or italicized words and terms can be found in the Definitions section at the end of this document.

WHO TO CALL IF YOU HAVE A QUESTION

If you have a question about a network provider, benefit, or claim, contact the *plan administrator* directly:

PLAN or PROGRAM	*Plan Administrator*	Member Services	Web Site
Comprehensive PPO Medical Plan	CIGNA HealthCare	(800) 244-6224	www.cigna.com
Prescription Drugs	Medco Health	800) 417-1916	www.medcohealth.com

PLEASE NOTE**:** addresses and additional contact information for the above administrators can be found in the Contacts section later in this booklet.

PNA BENEFITS CALL CENTER

If you then have additional questions about eligibility, coverage or about a specific claim, you or your covered dependent may then call the PNA Benefits Center at **(800) 685-4335**. The local number in the Toledo area is **(419) 247-4714.**

Call the PNA Benefits Center first if you have questions on one of the following:

- Eligibility
- Dependents
- Retiree health care contributions
- Appeals (also see the Appeals section of this booklet)

The PNA Benefits Center is available to answer your calls Monday through Friday (business days), from 8 am to 5 pm Eastern time.

HOW TO REPORT CHANGES

If you wish to change **your address**, contact the PNA Benefits Call Center.

If you experience a **life event** or ***family status change*** (see Definitions), you may have new benefit options available. To view your options and make your elections, visit the Pilkington North America benefits web site at **www.pna.employee.com**. Please review the information on the web site and

make your choices as soon as possible. Your choices can have a significant personal and financial impact on you and your family. Your prompt attention will ensure that you make the right choices and that your new benefits start on time. If you do not make a change within 30 days of the event, you will no longer be able to choose to revise certain options.

ALTERNATIVE PLANS

In some locations, *HMOs*, *EPOs* or other medical arrangements may be available. If you have chosen one of the alternative medical plans, the benefits available through that plan are not described in this booklet. However, the eligibility, enrollment, termination and other general provisions contained in this Summary Plan Description do apply. The following chart gives contact information if you have questions about the network, benefits or claims provided through an alternative healthcare plan.

PLAN ADMINISTRATOR	PHONE	WEB SITE
Kaiser (Lathrop)	(800) 464-4000	www.kaiserpermanente.org
OSF HMO (Ottawa)	(800) 673-5222	www.osfhealthplans.com
Paramount (Rossford)	(800) 462-3589	www.paramounthealthcare.com

CLAIMS

If you choose the Comprehensive PPO Plan and use a hospital, lab, or physician in the preferred provider network, that provider will file your claim for you. If you choose a provider who is not in the network, claim forms are available by calling your Plan Administrator at the number shown previously. Mail your claim to the applicable address shown in the following chart.

COMPREHENSIVE PPO PLAN MEDICAL CLAIMS (see ID Card for specific address)	**CIGNA HealthCare** P.O. Box 5200 Scranton, PA 18505-5200 CIGNA HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223
PRESCRIPTION DRUG CLAIMS	**Medco Health Solutions Inc.** P.O. Box 182050 Columbus, Ohio 43218-2050
HMO OR EPO MEDICAL CLAIMS	Contact the Plan (see Alternative Plans section above) or note the address on the ID card.

TIME LIMIT FOR FILING CLAIMS; UNCASHED CHECKS

Claims must be mailed or electronically delivered to the plan administrator within 18 months of the date of service. If a claim is paid and the check remains outstanding (is not cashed) for one year from date of issue (or is returned), the plan shall take reasonable steps to locate the payee. If the payee cannot be located, the amount owing to the payee shall be forfeited and

the Plan shall have no further liability therefore; provided if the payee makes a written claim for the payment within one year after the payment has been forfeited, the payment shall be made, without interest.

COMPREHENSIVE PPO MEDICAL PLAN - BENEFITS HIGHLIGHTS

The Company Health Care Program covers treatment of illness or injury that is not work related. "Illness" includes treatment related to the pregnancy of retirees and covered Spouses.

On the following pages, there are benefit charts for Medicare-eligible and Non-Medicare Eligible Participants who choose the Comprehensive Plan. The information below should be kept in mind as you review the charts and the benefit details presented in this Summary Plan Description:

- To be considered for coverage, all claims must be for Medically Necessary services or supplies.
- For Medicare-eligible Participants, the Plan is secondary to Medicare. It is not a supplemental plan. If Medicare has an obligation to pay what this plan would have otherwise paid, this plan will pay no more.
- Experimental, investigational or unproven procedures are not covered.
- Procedures which are not expected to lead to improvement are not covered.

The charts present a brief summary of the benefits available through each program. They do not fully describe your benefit coverage. For additional details on these benefits, please review the remainder of this booklet, the Plan document, or contact your healthcare provider.

Preferred Provider Plan (PPO) 80/60 Program
For Non-Medicare Eligible Retirees And Dependents

Benefit Provision	In-Network Care	Out-of-Network Care
Out-of-Pocket Maximums (Individual / Family) • Excludes deductible, co-payments, prescription drug expenses, amounts over "usual and customary"	2003 - $1,500 / $3,000 2004 - $1,600 / $3,200 2005 - $1,700 / $3,400	2003 - $2,500 / $5,000 2004 - $2,700 / $5,400 2005 - $2,900 / $5,800
Lifetime Maximum • Amounts counted toward the out-of-network life max. also count toward the in-network life max.	$1,000,000	$300,000
Physician Office Visits	100% after $15 co-payment *	60% after deductible
Adult Preventive Care		
Routine physical exams, including PSA	100% after $15 co-payment **	Not covered
Routine GYN exams, including routine PAP and Mammogram	100% after $15 co-payment *	60% after deductible
Pediatric Preventive Care		
Routine physical exams (age 6 and below)	100% after $15 co-payment *	Not covered
Pediatric immunizations (age 6 and below)	100% after $15 co-payment *	60% after deductible
Emergency Room Fee	100% after $50 co-payment* (waived if admitted)	60% after deductible***
Urgent Care Facility	100% after $25 co-payment *	60% after deductible
Deductible (Individual / Family) 2003 2004 2005	$250 / $600 $300 / $700 $350 / $800	$500 / $1,200 $600 / $1,400 $700 / $1,600
Co-insurance	80% after deductible until out-of-pocket max met, then 100%	60% after ded. until out-of-pocket max; then100%
Diagnostic Services (Lab, X-Ray and other tests)	80% after deductible	60% after deductible
Ambulance – Traditional, Air or Boat ****	80% after deductible	60% after deductible
Hospital Services (Inpatient and Outpatient)	80% after deductible	60% after deductible
Maternity (initial in-network test at $15 co-pay)	80% after deductible	60% after deductible
Medical/Surgical Services	80% after deductible	60% after deductible
Infertility Counseling, Testing and Treatment	80% after deductible	60% after deductible
Assisted Fertilization Procedures	80% after deductible	60% after deductible
	$5,000 Lifetime Maximum	
Organ Transplants (To receive 100% after ded., use LifeSource network.)	80% after deductible LifeSource: 100% after deduct.	60% after deductible
Physical, Restorative Speech, Occupational, and Cardiac Therapies	100% after $15 co-payment *	60% after deductible
	25 days/year	
Chiropractic	100% after $15 co-payment *	60% after deductible
	Limit: $1,000/year	
Durable Medical Equipment	80% after deductible	60% after deductible
Skilled Nursing Facility	80% after deductible	60% after deductible
	100 days/year	
Private Duty Nursing	80% after deductible	60% after deductible
Home Health Care	80% after deductible	60% after deductible
	100 visits/year	
Hospice	100% (not subject to deductible); Limit $12,000 life max.	

*** Not subject to the deductible.**
**** Subject to a $300 annual maximum in 2003, $350 in 2004 and $400 in 2005**
***** If out of network or not a true emergency**
****** If medically necessary**

Preferred Provider Plan (PPO) 80/60 Program
For Non-Medicare Eligible Retirees and Dependents

(page 2)

Benefit Provision	In-Network Care	Out-of-Network Care
Hearing Aids • $3,000 maximum per three year period • Including the hearing aids and intial testing and fitting • Members may access any discount programs provided by the claims administrator		
Mental Health Services *Inpatient*	80% after deductible	60% after deductible
	Inpatient Limit: 60 days/year	
Outpatient	80% after deductible	60% after deductible
	Outpatient Limit: 30 visits/year	
Substance Abuse Services *Inpatient*	80% after deductible	60% after deductible
Detoxification & Rehabilitation	45 days per year; $50,000 lifetime maximum	
	80% after deductible	60% after deductible
Outpatient	60 visits per year; 120 visits lifetime maximum	
Pre-certification, Case Management and Retrospective Review Requirements	As required by the Third Party Administrator	
Prescription Drug Program • Maintain use of closed formulary. The formulary is the MEDCO RxSelection Formulary with PNA exclusions. • Maintain mandatory Mail Order. (Two refills allowed at retail, then Mail Order thereafter.) • Participants may appeal to Medco concerning the medical necessity of a non-formulary multi-source brand name drug. If granted, days supply, co-insurance, and minimums and maximums will be the same as for formulary drugs. If not granted, there will be no coverage under the plan.	**Prescription Drug Deductible: $250 per person per year** Retail – 30 days supply Mail Order - 90 days supply **Retail and Mail Order Coinsurance:** 80% ***Retail*** Minimum co-insurance: 2003=$5 2004=$6 2005=$7 Maximum co-insurance: 2003=$50 2004=$60 2005=$70 ***Mail Order*** Minimum co-insurance: 2003=$10 2004=$12 2005=$14 Maximum co-insurance: 2003=$100 2004=$120 2005=$140	
Retiree Contribution • **Preferred Provider Plan and Drug Program** • **HMO/EPO and Drug Program**	Calculated based on the amount needed to satisfy the 4% cumulative annual limit on increased costs Pilkington North America will absorb.	
*** Not subject to the deductible**		

Important notes:

- This benefit chart shows only highlights. It does not fully describe the benefit coverage. Additional details are available in the remainder of this Summary Plan Description, in the contract and in the plan document.
- To be considered for coverage, all claims must be for Medically Necessary services or supplies.

Comprehensive Program (Secondary to Medicare)
For Medicare Eligible Retirees And Dependents

Benefit Provision	Benefits
Deductible (Individual / Family) 2003 2004 2005	 $300 / $600 $350 / $700 $400 / $800
Out-of-Pocket Maximums (Individual / Family) • Excludes deductible, co-payments, prescription drug expenses, amounts over "usual and customary"	2003 - $1,500 / $3,000 2004 - $1,600 / $3,200 2005 - $1,700 / $3,400
Lifetime Maximum • Lifetime maximum amounts counted in the Non-Medicare plan count toward the retiree lifetime maximum.	$1,000,000
Physician Office Visits	80% after deductible
Adult Preventive Care Routine physical exams, including PSA Routine GYN exams, including routine PAP & Mammogram **Pediatric Preventive Care** Routine physical exams (age 6 and below) Pediatric immunizations (age 6 and below)	 80% after deductible ** 80% after deductible 80% after deductible 80% after deductible
Emergency Room Fee ($50 co-pay waived if admitted)	100% after $50 co-payment *
Urgent Care Facility	80% after deductible
Co-insurance	80% after deductible until out-of-pocket max is met, then 100%
Diagnostic Services (Lab, X-Ray and other tests)	80% after deductible
Ambulance – Traditional, Air or Boat * **	80% after deductible
Hospital Services (Inpatient and Outpatient)	80% after deductible
Maternity	80% after deductible
Medical/Surgical Services	80% after deductible
Infertility Counseling, Testing and Treatment	80% after deductible
Assisted Fertilization Procedures	80% after deductible $5,000 Lifetime Maximum
Organ Transplants	80% after deductible (100% if a LifeSource Network Provider)
Physical, Restorative Speech, Occupational and Cardiac Therapies	80% after deductible 25 days/year
Chiropractic	80% after deductible Limit: $1,000/year
Durable Medical Equipment	80% after deductible
Skilled Nursing Facility	80% after deductible 100 days/year
Private Duty Nursing	80% after deductible
Home Health Care	80% after deductible 100 visits/year
Hospice	100% (not subject to deductible) Limit $12,000 lifetime maximum

*** Not subject to the deductible.**
**** Subject to a $300 annual maximum in 2003, $350 in 2004 and $400 in 2005**
***** If medically necessary**

Medicare Eligible (page 2)

Benefit Provision	Benefits
Hearing Aids • $3,000 maximum per three year period • Including the hearing aids and intial testing and fitting • Members may access any discount programs provided by the claims administrator	
Mental Health Services *Inpatient*	80% after deductible
	Inpatient Limit: 60 days/year
Outpatient	80% after deductible
	Outpatient Limit: 30 visits/year
Substance Abuse Services *Inpatient*	80% after deductible
Detoxification & Rehabilitation	45 days per year; $50,000 lifetime maximum
Outpatient	80% after deductible
	60 visits per year; 120 visits lifetime maximum
Pre-certification, Case Management, and Retrospective Review Requirements	As required by the Third Party Administrator
Prescription Drug Program • Maintain use of closed formulary. The formulary is the MEDCO RxSelections Formulary with PNA exclusions. • Maintain mandatory Mail Order. (Two refills allowed at retail, then Mail Order thereafter.) • Participants may appeal to Medco concerning the medical necessity of a non-formulary multi-source brand name drug. If granted, days supply, co-insurance, and minimums and maximums will be the same as for formulary drugs. If not granted, there will be no coverage under the plan.	**Prescription Drug Deductible: $250 per person per year** Retail – 30 days supply Mail Order - 90 days supply **Retail and Mail Order Coinsurance:** 80% ***Retail*** Minimum co-insurance: 2003=$5 2004=$6 2005=$7 Maximum co-insurance: 2003=$50 2004=$60 2005=$70 ***Mail Order*** Minimum co-insurance: 2003=$10 2004=$12 2005=$14 Maximum co-insurance: 2003=$100 2004=$120 2005=$140
Retiree Contribution • **Comprehensive Plan and Drug Program**	Calculated based on the amount needed to satisfy the 4% cumulative annual limit on increased costs Pilkington North America will absorb.
• **HMO/EPO/Supplements and Drug Program**	Calculated based on the amount needed to satisfy the 4% cumulative annual limit PLUS the incremental cost of the HMO/EPO/Supplements.

Important Notes:

- This benefit chart shows only highlights. It does not fully describe the benefit coverage. Additional details are available in the remainder of this Summary Plan Description, in the contract and in the plan document.
- To be considered for coverage, all claims must be for medically necessary services or supplies.
- This plan is secondary to Medicare. It is not a supplemental plan.

ANNUAL DEDUCTIBLES, CO-INSURANCE AND OUT-OF-POCKET MAXIMUMS
The Medical Plan includes a retiree deductible or family deductible applicable to eligible charges. Separate deductible amounts apply based on whether services are received in or outside of the preferred provider network. After the deductible has been satisfied, the Plan pays the co-insurance percentage shown in the above charts applied to the usual, reasonable and customary eligible expense, and the retiree or eligible dependent will pay the remaining co-insurance until a calendar maximum has been satisfied. After the annual out-of pocket expense maximum for single and family coverage has been satisfied, the Plan will pay 100% of eligible expenses for the remainder of the calendar year (unless the lifetime maximum has been reached). Separate out-of-maximums apply for in and out of network services.

LIFETIME MAXIMUM
The Preferred Provider Plan has a lifetime benefit of $1,000,000 for in-network services and $300,000 for out-of-network services. Amounts counted towards the $300,000 out-of-network lifetime maximum also count toward the in-network lifetime maximum. The Plan for Medicare-eligible retirees and surviving spouses has a $1,000,000 lifetime maximum. Amounts counted toward the Preferred Provider Plan also count toward the plan for Medicare-eligible participants.

Amounts from the Plans which had been administered by Unicare were carried over to the Plans administered by CIGNA effective April 1, 2003.

B. GENERAL INFORMATION

ELIGIBILITY

If you enroll in any available health care program, you may also be eligible to enroll your spouse and eligible dependents under the plan. You will be required to provide a copy of your marriage certificate and your child's birth certificate.

ELIGIBILITY – LATHROP, OTTAWA, ROSSFORD AND THE CLOSED PLANTS
An employee hired on or before December 31, 1988 at Lathrop, Ottawa, Rossford, and the closed plants (Charleston, Liberty Mirror, Mason City and Shreveport) who terminates PNA employment with at least 15 years of eligibility service in the Hourly Employees Pension Plan and is eligible for an immediate monthly retirement benefit will be eligible for post employment health care coverage.

- All employees on the seniority list who were age 40 or older on October 25, 1988, shall be grandfathered under the provisions of the 1985 General Agreement which required a minimum of 10 years of pension eligibility service (instead of 15 years) at retirement in order to be eligible for coverage continuation.
- An employee hired after December 31, 1988 and prior to June 29, 1998 at Rossford and prior to November 1, 1999 at Ottawa and Lathrop, will be eligible for post employment health care coverage upon termination of PNA employment, provided the employee
  - attained age 60 with at least 15 years of Company service; or
  - attained 30 years of Company service.

Company service is determined from the employee's most recent date of hire through the employee's date of termination.

ELIGIBILITY – LAURINBURG

An employee hired before August 1, 1997 at Laurinburg will be eligible for post-employment health care coverage upon termination of PNA employment, provided the employee had:

- attained age 60 with at least 15 years of Company service; or
- attained age 55 or older with combined age and service totaling 85 or more, or
- as of December 31, 1998, was age 60 or older and had 10 or more years of Company service.

ELIGIBILITY - DEPENDENTS

Eligible dependents of an eligible retiree include:

- A retiree's legal spouse, provided that if the spouse is employed full-time and offered health care benefits through his or her employer, the spouse must elect at least single coverage through his or her employer in order to be eligible for coverage under the Company's health care plans.

- A retiree's unmarried child from birth until the end of the month in which the child attains age 19 provided the child continues to meet the definition of eligible dependent under the Internal Revenue Code.

- A retiree's unmarried child beyond age 19 provided the child is a continuous full-time student in an accredited college or university and is principally dependent upon the retiree for support and maintenance.
  - In the event the retiree's child ceases to be a continuous full-time student (by reason other than graduation, illness, injury or unavailability of a class) prior to attaining the limiting age, coverage will end at the end of the month in which the child ceases to be a continuous full-time student.
  - In the event the retiree's child graduates prior to attaining age 23, coverage will be continued for an additional three months from the date of graduation but in no event later than the end of the month the child attains age 23.

  It will be the retiree's responsibility to notify the Company of a change in the child's student status and to provide documentation to the Company of continuous full-time student status upon request. The Plan Administrator may from time to time require evidence of the child's continuous full-time student status. A copy of your child's fee or class schedule, or a letter from the institution must be provided when requested.

- A retiree's unmarried child beyond age 19 if, prior to attaining age 19, the child is
  - incapable of self-sustaining employment by reason of mental retardation or physical disability,
  - principally dependent upon the employee or retiree for support and maintenance, and

- proof of the mental retardation or physical disability is furnished to the Company no later than 60 days after the date the child attains age 19.

It is the retiree's responsibility to provide documentation to the Company of continued proof of incapacity upon request.

A "child" is defined as follows:

- Natural born child, legally adopted child, or a child under court appointed guardianship provided the child is dependent upon the retiree for support and maintenance. An adopted child can be considered a "child" from the moment the child is placed in the custody of the retiree and the retiree's spouse, and

- Stepchild, when the stepchild resides in the retiree's household in a regular parent-child relationship and is principally dependent upon the retiree for support and maintenance.

ADDITIONAL DEPENDENT ELIGIBILITY RULES

- If both parents of a child are employees or retirees of the Company and eligible for health care benefits, only one may elect to cover the child as a dependent.

- For purposes of dependent eligibility, dependents of retirees in the following two classifications will be limited to those dependents (spouse and/or child) who were eligible dependents as of the date of the retiree's retirement; except that in the event the retiree adds an eligible spouse subsequent to his or her retirement ("New Eligible Spouse"), such New Eligible Spouse will be eligible for health care coverage. In the event of the retiree's death, a New Eligible Spouse will be eligible for continuation of coverage until the earlier of the date the New Eligible Spouse remarries or the number of months such deceased retiree and New Eligible Spouse were married. This section applies to:
  - Dependents of employees who retired on or after October 1, 1990 and prior to April 1, 2003 at Rossford,
  - Dependents of employees who retired on or after January 1, 1992 and prior to January 1, 2001 at Lathrop or Ottawa and prior to April 1, 2003 at the closed plants, and
  - Dependents of employees who retired prior to April 1, 2003 at the Closed Plants.

- The eligible dependents of a retiree who retired on or after January 1, 2001 at Lathrop or Ottawa and on or after April 1, 2003 at Rossford, Laurinburg and the closed plants will be limited to those dependents (spouse and/or children) who were eligible dependents as of the date of the retiree's retirement.

If a retiree enrolls his or her dependent within 30 days of the dependent's initial eligibility, coverage will be effective beginning on the first day of the dependent's eligibility unless the dependent (other than a newborn) is hospital confined. If a dependent is confined in a hospital, (other than a newborn) coverage will begin the first day following the dependent's discharge from the hospital.

- A newborn of a retiree's dependent child is not eligible for coverage.

- If a retiree does not enroll within 30 days of the date first eligible for coverage, such retiree and his or her dependents will not be eligible for coverage until the next open enrollment period.
- If a retiree or retiree's spouse and/or dependent children eligible for coverage under the PNA health care plan is enrolled in another employer's health care plan and subsequently loses coverage due to one of the events listed below (1–6), the retiree has 30 days from the date of the loss of coverage to enroll themselves, their spouses and/or their dependents in the PNA health care plan.
    - Discontinuation of healthcare coverage by the other employer,
    - Death,
    - Divorce,
    - Lay-off,
    - Retirement, or
    - Resignation

ELIGIBILITY FOR SURVIVING SPOUSES

- The Company will provide healthcare coverage for eligible surviving spouses and eligible dependents of deceased Lathrop, Ottawa, Rossford and closed plant employees who have coverage or are eligible for coverage as surviving spouses of employees who died on or after October 1, 1968, and prior to January 1, 1996.

  If the deceased employee was not eligible for or receiving a pension under a pension plan of the Company at the time of his or her death, health care coverage shall continue for a period equivalent to the number of complete calendar months of Company seniority the employee had at the time of his or her death. The cost of this coverage and the benefits provided shall be the same as for a retiree from the respective plant of the deceased employee.

- Surviving spouses of deceased Lathrop and Ottawa employees hired prior to November 1, 1999 and Rossford employees hired prior to June 29, 1998 who have coverage or are eligible for coverage as surviving spouses of employees who die on or after January 1, 1996, whether or not the employee is eligible for or receiving a pension under the Hourly Employees Pension Plan at the time of his or her death, shall be provided coverage by the Company until the earlier of:
    - the number of complete calendar months of Company seniority the employee had at the time of his or her death, or
    - the date the surviving spouse remarries.

  The cost of this coverage and benefits provided shall be the same as for a retiree from the respective plant of the deceased employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If you are eligible for coverage under a Company Healthcare plan, you may be required to provide coverage for your eligible children through a court order known as a Qualified Medical Child Support Order or QMCSO. A QMCSO is a judgment, decree, or order issued by a state court that creates or recognizes the existence of an eligible child's right to receive health care coverage, or enforces a state

law relating to coverage under Medicaid. The order must comply with applicable law, and must be approved and accepted by The Company as a QMCSO.

If the retiree cited in the QMCSO is already covered, coverage for a dependent required as the result of the QMCSO will be effective retroactive to the date of the court order, provided the court or the retiree requests the coverage within 30 days of the court order. If the court or retiree requests coverage after 30 days, coverage will be effective the first day of the month following the date the request was made.

If the retiree is not already covered, and a QMSCO requires that a child be covered, the retiree will automatically be enrolled as well. If the retiree resides in a state which requires the retiree to authorize payroll deductions for medical coverage and the retiree fails to do so, neither the retiree nor the child who was the subject of the QMCSO will be covered.

Other dependent children who are not the subject of the QMSCO and Spouses who were not previously covered will not be eligible to be covered until the effective date of the next open enrollment period.

FOSTER CHILDREN

Foster children are not eligible for dependent coverage (whether or not they live in your home).

ELIGIBILITY UPON A COBRA EVENT

Continuation of coverage for retirees will be subject to the Consolidated Omnibus Budget Reconciliation Act (COBRA). In 1986, the U.S. Congress enacted the COBRA law which, in certain cases, allows retirees, spouses or former spouses of retirees, and dependent children to elect to temporarily continue their health care coverage at group rates after their coverage would otherwise end. More information on COBRA eligibility and coverage may be found later in this Summary Plan Description.

SPONSORED DEPENDENTS

Sponsored dependent coverage is not available under the Company group health care program. Retirees with sponsored dependents who were covered as of the previous elimination of this program may continue such coverage until the dependent otherwise loses eligibility.

DUPLICATE COVERAGE

You are not eligible to be covered under more than one Company-sponsored healthcare plan at the same time. You are not eligible to be covered under any Company plan as both an employee or retiree, and a dependent. If you and your Spouse are both eligible for employee or post-employment coverage, only one of you may cover your eligible dependent children.

PRE-EXISTING CONDITIONS

The Company does not take into consideration any pre-existing conditions in determining eligibility for coverage and related benefits.

ENROLLMENT

WHEN YOU MAY ENROLL

New Retirees

Once you are officially retired, you will receive a letter advising that the web is available for you to enroll for your Health and Welfare benefits on the internet at **www.pna.employee.com** by the date given in the letter. If you were covered under a PNA healthcare plan prior to retirement and fail to make an election by that date, the comprehensive medical plan will be assigned as your default coverage, including any eligible dependents you covered as an active employee.

However,

- If you are enrolled in an alternative medical plan as an active employee, and there is a similar plan available to you as a retiree, you will be enrolled in that plan instead of the comprehensive medical plan.
- If you had waived medical coverage as an active employee, you will be considered to waive coverage in the retiree medical plan, but you are eligible to enroll later during the next Annual Enrollment, or at the time you have a family status change.

If you need further assistance, please contact the **PNA Benefits Center** at **(800) 685-4335** or in the Toledo area at **(419) 247-4714**.

Open Annual Enrollment

The Company will make every effort to offer every eligible retiree the ability to enroll or re-enroll on an annual basis, including retirees who have previously waived coverage. The Company reserves the right to adjust the date of the enrollment or re-enrollment due to business or other conditions.

EFFECTIVE DATE OF COVERAGE

New retirees who enroll in time will have coverage effective as of the date the retiree is first eligible. Existing retirees who enroll or re-enroll during an open enrollment period will have coverage effective the following January 1 (unless announced conditions warrant a change in the open enrollment period and subsequent effective date).

Coverage for your eligible and enrolled spouse and dependents is effective on the date the retiree's coverage begins (unless the spouse and dependents are added during a subsequent open enrollment period or due to a family status change).

If you have a family status change after your coverage begins, any newly eligible dependents will be covered on the date they become your dependents, provided you enroll on the website at **www.pna.employee.com** within 30 days of the event, and provide the required documentation.

COST OF COVERAGE

Retiree Medical Contribution and Available Coverage Levels

You and The Company share the cost of your medical plan. Retirees who elect to enroll pay a share of the estimated total cost incurred by The Company. The amount of your contribution will be announced prior to the open enrollment, and will depend on the program and coverage level chosen by the retiree.

Medical coverage levels:
- Retiree
- Family

Post-Employment Healthcare Limit

The Company and Union agreed to a limit on the future annual rate of increase in per capita health care costs to be borne by the Company for retirees, surviving spouses and their eligible dependents. Beginning with 1993 as the base year, if the actual rate of increase in per capita costs is expected to exceed 4% in any year, contributions from participating retirees and surviving spouses, or corresponding reductions in benefit levels will be required in order to achieve the 4% limit on Company cost increases.

- For purposes of the above calculation, the per capita cost for individuals who are not Medicare eligible was $789 as of January 1, 2003.

- For purposes of the above calculation, the per capita cost for individuals who are Medicare eligible was $239 as of January 1, 2003.

Per capita costs will be determined on a paid basis combining indemnity and PPO claims, HMO premiums, EPO claims, Prescription Drug claims and administrative fees. In addition, per capita costs will be determined separately for individuals under age 65 and those age 65 or older that are covered by Medicare.

Annually, the Company will determine the actual aggregate cost of paid retiree health benefits net of any contributions for the twelve month period ending in December of the year preceding the year for which retiree contributions are to be set. Based on an actuarial assessment, the actual aggregate experience will be allocated to average per capita costs which will then be compared to the maximum company costs for the year based on the 4% annual rate of increase since 1993 and any excess will be the required retiree contributions or corresponding reductions in benefit levels for that year.

- The actual paid per capita costs for prior years will be compared to those previously projected for the purposes of setting retiree contributions to determine if there was any surplus or deficit in retiree contributions, the amount of the deficit will be added to any required contributions for the next year. These adjustments will only apply for one year and do not become a permanent part of the contributions.

- Effective for claims paid on or after January 1, 2003, the actual paid per capita costs for prior years will be compared to those previously projected for the purposes of setting retiree contributions if there was any surplus or deficit in retiree contributions. The amount of the deficit or surplus will be added to or subtracted from any required contributions for the next year. These adjustments will only apply for one year and do not become a permanent part of the contributions.

WAIVING COVERAGE

You may choose to participate in the health care program or not. If you waive coverage under the Medical options, you automatically waive coverage under the prescription drug and the mental health and chemical dependency provisions of the Plan. If you waive coverage, you will not be able to enroll until the next open enrollment period unless you have a *family status change.*

WHEN YOU HAVE A LIFE EVENT OR A CHANGE IN STATUS

Please note: if you have a life event as outlined in the following sections, or a *family status change*, and that event results in a change in coverage, it is your responsibility to verify that your pension deduction (or invoice) is correct following the reported change. If it is not, please contact the Benefits Call Center at (800) 685-4335 as soon as possible.

If you report the error within three months:

- and had under-paid contributions, the under-payment will be collected retroactively to the first day of the current calendar year or the effective date of the change in coverage, whichever is later, or
- if you over-paid contributions, the over-payment will be refunded retroactively to the first day of the current calendar year or the effective date of the change in coverage, whichever is later.

If the amount deducted is incorrect and you do not notify the Benefits Call Center within three months following the effective date of the status change,

- and had under-paid contributions, the under-payment will be collected beginning with the date of coverage, or
- if you over-paid contributions, no contribution refunds will be made.

LIFE EVENTS

Normally, you may only enroll or change your elections when you first become eligible to participate and during open enrollment.

However, if you have a life event or family status change, you may revise certain benefit elections by reporting the event on the internet at **www.pna.employee.com** within 30 days. A family status change occurs when:

- Your legal marital status changes. Events that change your legal marital status include:
  - Marriage. If you are requesting coverage for a Spouse for the first time, you must provide a copy of your marriage certificate, or coverage will be canceled as of the enrollment date.
  - Death of Spouse
  - Divorce. If you are dropping a Spouse from your coverage because of a divorce, you will be asked to provide a copy of either the divorce decree showing the effective date of the divorce

or a letter from your attorney stating the effective date of the divorce. Coverage for the ineligible former Spouse will be canceled effective as of the date of the divorce.
  - Legal separation
  - Annulment

- Your dependents change. If you are requesting coverage for a dependent for the first time, you must provide a copy of your dependent's birth certificate or adoption record or record of legal guardianship. Events in this category include:
  - Birth
  - Adoption (including placement for adoption)
  - Your stepchild becomes an eligible dependent
  - You become the legal guardian for a dependent child
  - Death of a dependent child
  - Your dependent ceases to satisfy the requirements for coverage due to age, student status, or any circumstance as provided under this health plan

- Your Spouse or dependent loses or gains eligibility in his or her employer-sponsored health plan
- Your Spouse or dependent has a change in their employment status.

Your benefit change must be consistent with the change in status. For example, if you adopt a child, you may add a dependent in accord with the above rules.

If you report a life event or family status change within 30 days through the Pilkington North America web site at **www.pna.employee.com** , your benefit change will be effective on the date the status change occurred. If you fail to enroll your newly eligible Spouse or dependent within 30 days of the status change, you will not be able to enroll them until the next annual enrollment.

If you do not report a status change that would result in termination of coverage for you or your dependent (for instance, a divorce or a child leaving school):

- Expenses incurred after the date the Spouse or dependent lost eligibility will not be the responsibility of *The Plan*. You will be responsible to repay to the Company any ineligible premiums or claim payments made by the Plan on behalf of your ineligible Spouse or dependent, or reimbursements they or their healthcare provider received.
- In addition, you forfeit any retiree contributions for coverage made on behalf of the ineligible Spouse or dependent.

WHEN A PARTICIPANT HAS OTHER PLAN COVERAGE

HOW BENEFITS ARE COORDINATED

Benefits payable to you, your spouse, or your dependents under another employer's group plan, Medicare or other government-sponsored plans, or private insurance will be taken into consideration when determining benefits payable by The Company's Health Care Program. The Company's Health

Care Program's coordination of benefits provision is based on non-duplication / Medicare carve-out of benefits.

If there is no other coverage or the PNA Plan is primary, the Plan pays its regular benefits in full. If there is other coverage and the PNA plan is secondary, the PNA Plan pays a reduced amount that, when added to the benefits payable and the cash value of any services provided by the other plan, will equal the lesser of:

- The benefits normally paid by the Plan,
- The benefits normally paid by the Plan for the Medicare approved amount for the service, if the participant is eligible for Medicare, or
- 100% of the Reasonable and Customary charges actually incurred.

The amount the Company *Plan* pays is determined as follows:

- The plan that pays benefits first (the "primary" plan) is determined using *Uniform Order-Of-Benefit Determination Rules*. The Rules are shown following the chart below.
- When the *Company Plan* is primary, its normal benefits apply, regardless of what the other plan pays.
- When another plan is primary and has paid less than the Plan's normal benefit, the Plan will pay the difference between what it would have paid if it were the primary plan and that paid by the primary plan (unless Medicare is the primary plan).
- If Medicare is the primary plan, the Plan will pay the difference between the amount it would normally have paid (based on the Medicare-approved amount for the services) and the amount actually paid by Medicare (the "carve-out" method of coordination).

Following are two examples of how non-duplication of benefits is applied when the Company *Plan* is secondary, assuming the *Plan* would have paid $240 had it been the primary plan:

Example 1		**Example 2**	
Total charges	$300	Total charges	$300
Primary plan pays	$240	Primary plan pays	$210
Amount the Plan *would have* paid	- 240	Amount the Plan *would have* paid	- 240
The *Plan* pays	$ 0	The *Plan* pays	$ 30

The *Uniform Order-of-benefit Determination Rules* are:

- A plan with no provision for coordination with other benefits will be considered to pay its benefits before a plan that contains such a provision.
- A plan that covers a person as an employee pays its benefits before a plan that covers the individual as a retiree or as a dependent.

- Except in the case of a legally separated or divorced retiree, the plan that covers an individual as a dependent child of a person whose birthday comes first in a calendar year will pay its benefits before a plan that covers the individual as a dependent child of a person whose birthday comes later that calendar year.
- In the case of a dependent child whose parents are divorced or legally separated, the following rules apply:
  - Where there is a court decree that makes one parent financially responsible for the health care expenses of the child, that parent's plan will pay its benefits before the plan of the other parent.
  - Where there is no court decree and the parent with custody of the child has not remarried, that parent's plan will pay its benefits before the plan of the parent without custody.
  - Where there is no court decree and the parent with custody of the child has remarried, that parent's plan will pay its benefits first, the step-parent's plan will pay its benefits second, and the plan of the parent without custody will pay its benefits last.
- A plan covering a person as an active employee will pay its benefits before a plan covering a person as a COBRA, laid-off, terminated, or retired employee.
- Where the above rules do not establish the order of payment, the plan that has covered the person for the longer period of time will pay its benefits before the other.
- The Plan Administrator has the right to release or obtain any information and make or recover any payments it considers necessary to administer this provision. The Company health care plans coordinate benefits among each other following these same rules.

MEDICARE

These are only the highlights of the Medicare program, presented for general information purposes only. It is important for you to obtain more detailed information from the U.S. Department of Health and Human Services and then review your personal eligibility for Medicare and specific Medicare benefit details.

WHAT MEDICARE COVERS

Medicare is a medical benefit plan administered by the federal government which provides benefits for persons who have reached Medicare's "normal retirement age", and for some disabled persons under age 65:

- **Medicare Part A** pays benefits for inpatient hospital care, skilled nursing facility care, home health care, and hospice care.
- **Medicare Part B** pays benefits for physician services, diagnostic X-ray and laboratory tests, emergency room care, and radiation treatments.
- **Medicare Part D** provides prescription drug benefits.

MEDICARE RULES (primary/secondary status of the Plan with respect to Medicare)

Medicare is the primary payer of medical claim coverage provided to a retired employee who is Medicare-eligible or the spouse of a retired employee who is Medicare-eligible.

An individual becomes eligible for Medicare:

- When he or she reaches Medicare's normal retirement age,
- After having received Social Security disability benefits for a period of 24 months, or
- If he or she suffers from end-stage renal disease.

In the first two situations listed above, Medicare coverage is primary and the Company-sponsored coverage is secondary.

In the case of end-stage renal disease, Medicare is primary for those who have reached Medicare's normal retirement age. For those with end-stage renal disease who have not reached Medicare's normal retirement age, Medicare assumes the primary insurer role after the first 30 months. You must enroll in Medicare when it is the primary coverage over the Company Plan.

Medicare's "Normal Retirement Age"

Your Medicare normal retirement age depends on the year you were born, as follows:

Year of Birth	Normal Retirement Age
1937 and prior	65
1937	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943-54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Please note: Persons born on January 1 of any year should refer to the normal retirement age for the previous year.

If you or your spouse has reached Medicare's normal retirement age, you should contact Medicare to enroll in Part A as a secondary benefit (it requires no contribution). When your active coverage from the Company ceases, contact Social Security immediately to activate Part B. Current federal legislation has waived the waiting period penalty and the contribution penalty on this kind of delayed enrollment in Part B.

If You Retire at Medicare's Normal Retirement Age

If you plan to retire at Medicare's normal retirement age, you (and your spouse, if he or she has attained Medicare's normal retirement age) must enroll for Medicare during the three-month period before your normal retirement age (or before your retirement date, if you retire after your normal

retirement age). If you don't enroll when you're first eligible, there may be a delay in the effective date of your Medicare coverage, and there may be a permanent increase in your Medicare Part B monthly premium. If you are eligible for retiree health care coverage, that plan will assume you have Medicare regardless of whether you are actually enrolled.

If You Stop Working Due to a Disability

Your coverage under the Company Plan ends after you stop working, unless you are eligible for extended benefits or elect COBRA coverage. It is important to apply for Social Security when you have been disabled for five months and expect to remain disabled for one year. If you qualify for Social Security disability benefits, after 24 months of payments you will be notified by the government of your enrollment in Medicare Part A and your entitlement to enroll in Part B. If you don't enroll when you're first eligible, there may be a delay in the effective date of your Part B coverage, and there may be a permanent increase in your monthly premium.

If Your Dependent Becomes Disabled

If a covered spouse or dependent is disabled and becomes eligible for Medicare, Medicare will provide the primary medical coverage. The spouse or dependent must also enroll in Medicare Part B. The Company Plan will be secondary.

End-Stage Renal Disease

If you, your spouse or dependent have end-stage renal disease and have not yet attained the Medicare normal retirement age to qualify for Medicare benefits, the Company Medical Plan will provide the primary coverage for a period of 30 months, beginning with the month renal dialysis starts (or the date of a kidney transplant, if earlier). Upon the earlier of 30 months ar attainment of Medicare's normal retirement age, Medicare will be the primary coverage, with the Company's Plan as secondary. This means that benefits provided for services covered under the Medical Plan will be reduced by any Medicare benefits payable (even if the person is not enrolled under Medicare).

Participants in this situation should enroll in Medicare Parts A and B effective on the earlier of the:

- Third month after the month in which renal dialysis starts, or
- Date of a kidney transplant, or
- First month in which you or a dependent are admitted to a hospital in preparation of a kidney transplant if that occurs within two months.

If participating in a self-care dialysis training program before the end of the 3-month period following commencement of a regular course of dialysis, Medicare benefits are available as of the beginning of the dialysis treatment and you should enroll then.

IF YOU WAIVE MEDICARE COVERAGE

If you do not enroll in Medicare, claims submitted to Company-sponsored plans will still be calculated based on the assumption that Medicare coverage was accepted.

REIMBURSEMENT, SUBROGATION, RIGHT OF RECOVERY

If you are injured by another person (third party), you have a right to collect for those injuries. If the *Company Plan* reimburses you for the expenses related to those injuries, the *Plan* has the right to be reimbursed for any amounts you receive from a judgment, settlement, or otherwise. Similarly, if the *Plan* pays a claim in error, it has the right to recover the monies paid.

Once an erroneous payment or an accident or injury claim is identified, payment of health care expenses will be limited to $1,000 while the *Plan* determines whether there is a right of reimbursement and/or subrogation. Whether or not you sign a form acknowledging the *Plan's* rights, the *Company Plan* will be entitled to its subrogation or recovery rights. Whether or not you are fully compensated for your injury, the Plan has a right to recover, through either reimbursement or subrogation, any or all claims the Plan has paid (or is obligated to pay) with regard to your injury.

RIGHT OF REIMBURSEMENT

If the *Plan* pays benefits due to an injury caused by a third party or due to an administrative error to you or your provider, the *Plan* has the right to be reimbursed by the party receiving the payment. To enforce its rights, the *Plan* may take any necessary action, including taking legal action and/or withholding the amount of the payment from future payments to, or on behalf of you and/or the provider.

SUBROGATION / RIGHT OF RECOVERY

If the *Company Plan* reimburses you or your provider for injuries caused by a third party or due to an administrative error, the *Plan* has the right to recover the reimbursement directly from the third party – including the right to file suit in your name, if necessary.

WHEN HEALTH COVERAGE ENDS

EVENTS WHICH END COVERAGE

Coverage under the Health Care Program generally ends on the earliest of the following dates:

- The last day of the month in which you cancel coverage
- The last day of any month prior to any month for which you do not pay your contributions for health care coverage
- The last day of the month that your eligibility for coverage ends
- The day you die
- The date the Plan is terminated

Spouse and dependent coverage generally ends on the earliest of the following dates:

- The date your coverage ends (unless your coverage ends because you die, in which case dependent coverage will end as specified in the section entitled " ELIGIBILITY FOR SURVIVING SPOUSES AND DEPENDENTS"),
- The date of divorce,
- The date the dependent is no longer eligible for coverage, or
- The last day of the month in which you cancel coverage for your Spouse or dependent.

OPTIONAL CONTINUED COVERAGE (COBRA)

When coverage for you, your Spouse or a dependent ends, Federal Law specifies that in certain circumstances you may have the right to continue coverage for a limited period of time. For more information on your rights, see the COBRA section entitled "FEDERAL LAW: NOTICES AND REQUIREMENTS".

C. HEALTHCARE BENEFITS

MEDICAL PLAN

The Medical Plan covers eligible expenses for the care and treatment of non-work-related illness (sickness, disease, or pregnancy, including complications) and injury (an unexpected accidental injury to the body). To be covered, charges must be:

- *Medically necessary* care and treatment,
- Prescribed or ordered by the attending physician, and
- Obtained from a *Preferred Provider* or within *Reasonable and Customary (R&C)* charge limits

PREFERRED PROVIDER PROGRAM

The Comprehensive PPO Medical Plan is a plan offered to retirees and dependents who are not Medicare-eligible. When obtaining services covered under the Comprehensive PPO Plan, plan participants may choose a provider each time they obtain services, and do not have to designate a Primary Care Physician.

Under a PPO network, hospitals, labs and doctors have contracted to provide services at negotiated, reduced fees. Because of the discounted fees, both you and the Company save money. You may choose to see a provider whenever you or a dependent needs medical care. The choice is yours:that belongs to the network or a provider that does not belong to the network

- If you use a network provider, your benefits will be paid at a higher level.
- If you use a non-network provider, your benefits will be paid at a lower level. Out of network, medical claim coverage is based on “reasonable and customary” charges.

For non-Medicare eligible retirees in the Toledo area, CIGNA pays claims, however the preferred provider network is the FrontPath Health Coalition. Toledo-area network providers may be found by checking the FrontPath internet site at **www.FrontPathcoalition.com** or by calling them at **(419) 891-5207.**

For non-Medicare eligible retirees (and those traveling) outside the Toledo area, the list (or network) of healthcare providers in the *Preferred Provider Organization (PPO)* is available through CIGNA HealthCare on their internet site, **www.cigna.com** or by calling CIGNA's Member Services at **(800) 244-6224**. Participants may also choose providers who are not in the preferred network. However, the benefit reimbursement level is lower if you obtain services outside the preferred network.

BEFORE OBTAINING TREATMENT IN A HOSPITAL

The Comprehensive PPO Medical Plan includes a utilization review program to manage your costs and the plan's costs by reviewing whether proposed treatment plans are medically necessary. This program includes:

- Pre-certification for hospital admissions
- Continued stay review
- Discharge planning, and Case management

If you do not follow the requirements of this utilization review program, your benefits may be reduced or your expenses may not be covered.

Before you or one of your covered dependents is admitted to a hospital for *non-emergency care*, you or your doctor must call CIGNA, a (800) 244-6224. CIGNA will evaluate the proposed admission plan and length of stay based on your individual treatment needs and the medical care standards in your community.
If you or a covered dependent is hospitalized for an *emergency*, it is your responsibility to make sure CIGNA is notified within two business days after the admission.

If your hospital stay must be extended beyond the number of days originally authorized, your doctor may request an extension-of-stay authorization from CIGNA. You will be notified of any additional days that are authorized.

SECOND OPINIONS

You may obtain a voluntary second opinion from a board-certified doctor of your choosing. A voluntary second opinion must be obtained from a physician who is not associated or in practice with the doctor who originally recommended the medical procedure.

Voluntary second opinions do not affect the CIGNA decision as to coverage under the plan. A voluntary second opinion just allows the retiree more information on which to base a decision about having the procedure or not.

The charges of a consulting physician for a second opinion consultation, including the charges for *medically necessary* laboratory and x-ray examinations made in connection with the second opinion consultation, and any written reports from the consulting physician, are covered at the same benefit level as the original physician visit.

The Plan does not cover second opinions for normal obstetrical procedures, procedures not covered under the Plan, nor minor surgical procedures not requiring a general anesthetic.

NON-COMPLIANCE PENALTIES

Charges for Claims which were not *Medically Necessary*

Charges for services and supplies which were not Medically Necessary (as determined by the claims administrator, Plan Administrator, or utilization review administrator) for the diagnosis, care, or treatment of a physical or mental condition, are not covered by any Pilkington North America Plan, even if prescribed and recommended by a physician.

COVERED MEDCAL EXPENSES

This Section gives the explanations and limitations of specific program features of the *Company* Comprehensive PPO Plan. In all cases the service must be *Medically Necessary* and the result of a non-occupational injury, illness or pregnancy.

Preventive Care

The chart shown previously highlights the preventive coverage available under this *Plan*. Under the Comprehensive PPO Plan, the cost of physical assessments for retirees and Spouses is covered as indicated.

Well-child coverage is also provided under the Comprehensive PPO plan for routine physical examinations, required immunizations, inoculations, and TB Tine tests through age 6. For information on the allowed number and type of well-child services, call CIGNA at 1-800-244-6224.

Immunizations are covered only as a part of an adult (age 18 or over) *Routine Physical Exam* or under the well-baby program. Free or low-cost immunizations may also be available through local Health Departments and agencies.

Facility Charges

Birthing Centers

Charges made by a Birthing Center for the following services and supplies are covered:

- Prenatal care.
- Childbirth.
- Postpartum care rendered within 24 hours after delivery.

Only those charges for pregnancy related services usually covered under the Plan will be covered when rendered by a Birthing Center.

Convalescent Care

Charges incurred from a Medicare-approved *Convalescent Facility* are covered for up to 120 days per disability during a *Convalescent Period*. Confinement in a *Convalescent Facility* must begin within 14 days after a *Hospital* confinement, which must have been at least three consecutive days. Coverage includes:

- Semi-private room and board. Private accommodations will be covered at the average daily rate for semi-private accommodations.
- Use of special treatment rooms; x-ray and laboratory examination;
- Physical, occupational or speech therapy; oxygen and related therapy; and other necessary medical services.
- Drugs, solutions, dressings, and casts, but no other supplies.

Convalescent Care expenses do NOT include care for mental disorders, drug addiction, chronic brain syndrome, alcoholism, mental retardation, senile deterioration or *Custodial Care*.

Hospice

Hospice care serves primarily to provide pain relief and supportive care to a terminally ill patient. For the hospice services to be covered by the Plan, the patient's physician must certify that the patient has six months or less to live. Also, a Medicare-certified hospice agency or facility must provide the services, and the hospice care must be pre-certified.

The Plan covers the following hospice care services and supplies:

- Room, board, services, and supplies,
- Nursing care for up to eight hours per day (except for the patient's final days, when nursing care may include around-the-clock care),
- Medical social services,
- Counseling by a registered dietician,
- Medically necessary services by providers who are not part of the hospice care agency,
- Medical supplies, drugs, and medicines prescribed by a physician,
- Physician services,
- Psychological, social, and spiritual counseling, and
- Bereavement counseling to immediate family members.

The Plan does not cover certain hospice care expenses, including (but not limited to):

- Funeral arrangements,
- Financial or legal counseling, including estate planning or the drafting of a will,
- Services provided by a volunteer or member of the patient's household or immediate family, and
- Homemaker or caretaker services, which are services not solely related to the medical care of the patient.

Hospital Charges

These are defined as all necessary expenses billed by a *Hospital*, *Urgent Care Center*, or *Clinic*. The Plan covers the following services and supplies billed by such facilities when medically necessary:

- Semi-private room and board,
- Private room when medically necessary and ordered by the attending physician,
- Nursing care, except for private-duty nursing care,
- Meals and special diets,
- Operating room, pre-operating room, other surgical treatment rooms, recovery room, and delivery room,
- Anesthesia, supplies, and anesthesiologist fees,
- Laboratory examinations, including pathologist fees, typing of blood donors, and lab services,

- EKG, X-ray diagnostic service, X-ray therapy, radiologist fees, and related services,
- CAT scans, MRIs, and other high-tech diagnostic services,
- Radium, cobalt, and radioactive isotopes,
- Respiratory and oxygen therapy,
- Drugs and medicines (home-going drugs are not covered by the Medical Plan but may be covered by the Prescription Drug Program),
- Materials used in wound care, dressings, and casts,
- Intensive care and special care (e.g., burn care or cardiac) units, and
- Physical rehabilitative services, including nursing, physical therapy, speech and hearing therapy, and functional/occupational therapy.

Emergency room visits are subject to a $50.00 co-payment. The co-payment is waived if admission to the hospital occurs. The Emergency Room benefit is administered on the basis of signs or symptoms shown by the patient as verified by the physician at the time of treatment, rather than on the basis of the final diagnosis. A medical emergency will not be considered to exist if treatment is not secured within seventy-two (72) hours of the onset of the condition.

Skilled Nursing Facility

Treatment in a skilled nursing care facility is for cases when it is necessary for non-custodial skilled services to be provided on an inpatient basis, and the necessary services are less intense than those provided through a hospital but more intense than those available from home health care.

Skilled care facility services performed in a skilled nursing home, sub-acute unit, transitional unit connected to a hospital or in a rehabilitation hospital will be covered for maximum periods as listed previously. The benefit days will commence on the first day any payment by the plan is made. All skilled facility admissions regardless of age must be pre-certified with the utilization review vendor for intensity of services, eligibility and the above criteria.

To qualify for benefits, the *retiree* or eligible dependent must meet all of the following requirements:

- Skilled nursing services or skilled rehabilitation/restorative services must be performed by or under the direct supervision of a licensed professional.
- The skilled services must be performed on a daily basis.
- The skilled services can only be provided on an inpatient basis but the intensity of services are less than those for general acute hospital but greater than those available to the covered person in their home.
- The condition must be temporary in nature, treatable and the patient must be expected to improve to a predictable level of recovery. If the patient reaches a plateau or maximum level of recovery possible for that particular condition and /or the condition is not expected to improve to a predictable level of recovery, services will no longer be considered skilled in nature.
- The care must not be custodial.

- Skilled care services provided on a part-time or intermittent basis (less than daily and up to eight hours per day), which cannot be accessed on an outpatient basis, and do not meet the definition for skilled facility services may be covered services under Home Health Care. Home health care services must be prescribed by a physician and medically necessary.

When the above conditions have been met, the Plan covers the following skilled nursing care services and supplies:

- Semi-private room service, including general nursing care, meals, and specific diets,
- Use of special treatment rooms,
- Laboratory examinations,
- Physical, occupational, and speech therapy treatments,
- Oxygen and other gas therapy,
- Drugs, biologicals, and solutions used while the patient is in the facility,
- Materials used in dressings and casts, and
- Durable medical equipment.

Physicians Charges

Office Visits

The Plan covers physician office visits that are necessary due to an injury, illness, or pregnancy.

Surgical Expenses

Surgical services are operative procedures for the necessary diagnosis and treatment of diseases, injuries, fractures, or dislocations. The Plan covers surgical services and the assistance of another physician (if the attending physician certifies that interns, residents, or house staff members are not available).

Cosmetic or re-constructive surgery is covered only for:

- The correction of congenital anomalies (regardless of the patient's age),
- The correction of conditions resulting from accidental injuries or traumatic scars, or
- The correction of deformities resulting from cancer surgery or following medically necessary mastectomies.

For multiple surgical procedures, the following provisions apply:

- When performed through a single incision, the primary procedure is covered under the Plan. The secondary procedures would be incidental and not a covered service.
- When performed through separate incisions, the primary procedure is covered at 100% of the R&C charge, the next greater procedure is covered at 50%, the third at 25%, the fourth at 10%, and the fifth at 5%. If there are more than five incisions, the claim will get individual consideration.

Obstetrical Services

Charges for obstetrical services are covered on the same basis as surgical expenses.

PRESCRIPTION DRUG BENEFITS

If you enroll in a Medical Plan, you and any covered eligible dependents are automatically covered by the Prescription Drug Plan. The Plan is administered by Medco Health Solutions, which is the administrator of the retail pharmacy network and claims and of the mail order service claims.

Medco has a national network of over 56,000 retail pharmacies that have contracted to provide prescription drugs for negotiated, reduced rates. Whenever you need prescription drugs, you may choose to use a pharmacy that belongs to the Medco network or a pharmacy that does not belong to the network. The choice is yours to make. However, if you use a Medco network pharmacy, your benefits will generally be paid at a higher level

What Drugs are Covered

The prescription drug plan covers drugs on the Medco formulary. A "formulary" is a list of covered drugs. The list is assembled and periodically revised by a Medco committee of pharmacists and physicians. Medco has a number of formularies. The Medco formulary list which applies to eligible participants in this health *Plan* is the Medco **RxSelections Formulary,** subject to the exclusions noted later in this section.

To find out if a medication your doctor is prescribing is covered by the Plan, you or your doctor may call Medco Member Services at **(800) 417-1916**, or after you've registered online you may check the Medco web site at **www.medcohealth.com.**

The Medco Prescription Drug formulary covers medically necessary drugs and supplies that are prescribed by your physician, dentist, or other persons or organizations licensed to prescribe medication. Coverage includes the following:

- Federal legend prescription drugs
- Injectable insulin and diabetic supplies (syringes, needles, lancets, test strips
- Disposable syringes and needles for injecting insulin when purchased with insulin

The following prescription drugs are covered only with a prior authorization by Medco, including diagnosis certification:

- Betaseron/Avonex
- CNS stimulants (amphetamines)
- Cognex/Aricept
- Copaxone
- Crinone
- Erythroid stimulants (Procit and Epogen)
- Myeloid stimulants (Neupogen and Leukine)
- Growth hormones
- Immunomodulators (Interferon)

- Retin-A if used to treat pre-cancerous conditions or acne vulgaris
- Pulmozyme
- Testosterone

The following prescription drugs will be covered, subject to the requirements noted.

- Angiotensin Receptor Agonists (Medco review of previous medication history. If none, prior authorization is needed)
- Cox II's (if over age 65 or previous medical history. If neither, prior authorization is needed)
- Erectile Dysfunction Agents (limits to 6 for 30 days or 18 for 90 days, if more, prior auth. is needed)
- Rebetol (previous medication history, if none, p.a. is needed)

How the Prescription Drug Plan Works

There is a two (2) refill limit on all maintenance medications filled at a retail pharmacy. After the prescription has been refilled two times, you must send through the mail order service to receive additional supplies of that medication.

Medco Network Retail Pharmacy Service

To fill or refill a prescription at a participating network pharmacy, you simply present your Medco identification card and pay the appropriate co-insurance for each medication you receive. **Pharmacies** in the **Medco network** will submit all claims to Medco for payment. If you use **a non-network retail pharmacy**, you must pay the provider in full for the prescription, obtain an itemized receipt, and submit a claim for reimbursement yourself to Medco. To submit such a claim, you need to call Medco at **(800) 417-1916** and request a claim form.

You can normally get up to a 30 day supply plus two (2) refills for each prescription at a retail pharmacy. After that, you must use the mail order service where you can get up to a 90 day supply. These provisions may not apply if:

- The prescription is filled and dispensed by a nursing home in which the patient is confined, or
- The prescription is for a Level II controlled substance, or
- The drug manufacturer recommends that the medication be dispensed in a supply of 30 days or less (for instance Accutane), or
- Federal or other laws prohibit mailing the drug.

Out of Network Retail Pharmacies

To fill or refill a prescription at a pharmacy which is not in the Medco network, you pay the full cost of the prescription to the pharmacy. You may then file a claim for the expense, and Medco will reimburse you the amount the Plan would have paid a participating network pharmacy. (A non-network pharmacy may cost you more because there are no negotiated drug discounts.)

Medco Mail Order Service

If your doctor prescribes a maintenance medication (for example, heart, diabetes, or cholesterol medicine), you are required to have the prescription filled through the Medco mail order service. You may get up to a 90 day supply of your prescribed medication each time through the mail order service.

To order your medication through the mail order service --

- Let your physician know you are covered by a mail order prescription drug service.
- Ask him or her to write your prescription for the mail order service showing that Medco should dispense up to a 90 day supply. The doctor should also indicate any refill limits.
- Mail the prescription to Medco Rx Services using a Medco Rx Services envelope. Be sure to write your Medco ID number or Social Security number on your prescriptions, and include the appropriate coinsurance amount. If you are unsure of the amount, you may pay by credit card. Or you may call Medco Customer Service at **(800) 417-1916** for an estimate.
- You should receive your medication at your home in about 10-14 days from the date you mail your order.

When it's time for you to order a refill from the mail order service, you may --

- Phone in your refill order using EasyRx. Medco Rx Services will process your request within 48 hours. You will receive the refill order in about one week.
- Mail in your refill order. It will take about 10-14 days for delivery from the time you mail in your refill order to Medco Rx Services.
- Use the Internet to re-fill your order by visiting the Medco website at **www.medcohealth.com**. Orders requested through the website will take up to 7 to 10 days for delivery.
- You may pay for your mail order drugs by check or money order made payable to "Medco Rx Services." You may also authorize Medco to bill your credit card directly if you use either MasterCARD®, VISA® or DISCOVER®.
- If you decide to send a check or money order for your mail order prescription and don't know how much to send, you may contact Medco Member Services at **(800) 417-1916**. You will need to provide the name of the medication, or the prescription number if the order is for a refill. If you send a check or money order and overpay your account, Medco will credit your account.
- If you send a check or money order and there is a balance of $100 or less due, Medco will send you a bill along with your prescription. If you fail to pay any balance due within 120 days, you will be required to pay 100% co-insurance on new or re-filled prescriptions until all past balances are collected by Medco. Once you are caught up, the standard co-insurance will apply to new or re-fill prescriptions from then on. (There will be no retroactive adjustment of the penalty claims processed at the 100% coinsurance level.)
- If there is a balance of more than $100 due, Medco will attempt to contact you to give you your options. If you fail to respond in a timely manner, your prescription will be removed from the Medco system.

To make the mail-order systems work better for you:

- When you order refills using the automated Refill by Phone feature (EasyRx) or through the Medco website, have your identification and prescription numbers handy.
- To make sure you get your refill on a timely basis, re-order on or after the refill date shown on the refill slip, or when you have fewer than 14 days of medication remaining.

What the Drug Program Does Not Cover (Exclusions)

The Prescription Drug Program does not cover certain drugs, including (but not limited to) the following:

- Allergens
- Antineoplastic agents
- Anti-obesity agents
- Charges for administering prescription drugs and insulin
- Diabetic supplies (Exceptions: test strips are covered; needles and lancets are covered if written on the same prescription as the insulin.)
- Diagnostics
- Fertility agents
- Gold compounds
- Injectable androgenic agents
- Injectable antacids
- Injectable antihistamines
- Injectable muscle relaxants
- Irrigation solutions
- Male and female contraceptive devices and topical contraceptives
- Miscellaneous medical supplies
- More than a 30 day supply dispensed at one time by a retail pharmacy
- More than a 90 day supply dispensed at one time by the mail order pharmacy
- Over the counter medications
- Prescription refills over the amount prescribed by your provider
- Products used for cosmetic purposes, including Rogaine
- Reusable syringes with or without needles
- Therapeutic devices or appliances, regardless of their intended use
- Toxids, serums and vaccines

OTHER MEDICAL EXPENSES

The Plan also covers the following services when they are medically necessary:

- Allergy testing and injections
- Ambulance service (including air or boat ambulance services in certain situations)
- Anesthesia in conjunction with another eligible covered service
- Audiometric exams, hearing aid evaluation tests, and hearing aids (up to two hearing aids in a 36-month period)
- Behavioral Expenses
- Cataract Surgery: Eyeglasses Or Contact Lenses Following Cataract Surgery
- Chemical Dependency, including alcoholism treatment
- Chemotherapy
- Chiropractic services, including X-rays, diagnostic lab tests, adjustments, traction, and kinesiotherapy. These services are subject to an annual maximum of $1,000 per person, provided the services are medically necessary, subject to the claims administrator guidelines.
- Oral surgery (if the need for such surgery was directly caused by an illness or injury).
- Diagnostic Tests
- Drugs And Medicine (see section on Prescription Drugs)
- Durable medical equipment (such as wheelchairs and hospital beds) rental or purchase, depending on the claim administrator's determination
- Emergency room visits in the case of an emergency
- Genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - You have symptoms or signs of a genetically-linked inheritable disease;
  - It has been determined that you are at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
  - The therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

  Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically linked inheritable disease.

  Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to three (3) visits per contract year for both pre- and post- genetic testing.

- Hearing Aids and Exams. Initial medical examination of the ear, audiometric examination and hearing aid evaluation tests and hearing aid devices are covered. These services are subject to a $3,000 per person maximum once every three years.
- Hemodialysis – use of artificial kidney machine
- Home Health Care

  Home health care is hospital or skilled nursing care services provided in the patient's home as an alternative to hospitalization or care in a skilled nursing facility. For the Plan to cover the home health care, the patient's physician must refer him or her, the care must be provided by a home health care agency, and the home health care must be pre-certified as medically necessary and appropriate by the utilization review administrator. The Plan covers the following home health care services and supplies if they are included in a treatment plan prescribed by your physician:

  - Nursing care for up to eight hours per day
  - Physical, occupational, or speech therapy
  - Dietary guidance
  - Prescription drugs not available through the Prescription Drug Plan
  - Central supplies (e.g., bandages, oxygen, hypodermic needles, catheters, and colostomy appliances)
  - Laboratory tests

  The Plan does not cover certain home health care expenses, including (but not limited to):

  - Home health aide services
  - Services or supplies not specified in the treatment plan
  - Services of a social worker
  - 24-hour nursing care
  - Services provided in a hospice care program
  - Services excluded under Hospice Care services
- Hyperbaric chamber oxygenation
- Infertility treatment, including infertility drugs
- Laboratory and X-ray tests, services, and materials
- Massage therapy performed by a licensed massage therapist is covered as outpatient physical therapy when it is ordered by a physician and accompanied by an appropriate diagnosis,
- Maternity care (not covered for dependent children except for care required because of complications), including routine prenatal and postnatal care,
- Mouth, Jaw, And Teeth

Coverage under the Medical Plan is provided for services rendered and supplies needed for treatment of, or related to, conditions of the teeth, mouth, jaw, jaw joints or supporting tissues (including bones, muscles and nerves) only as specified below:

- Surgery needed to treat a fracture, dislocation or wound.
- Surgery needed to cut out:
  - Teeth partly or completely impacted in the bone of the jaw.
  - Teeth that will not erupt through the gum.
  - Other teeth that cannot be removed without cutting into bone.
  - The roots of a tooth without removing the entire tooth.
  - Cysts, tumors or other diseased tissues.
  - Retained roots which were left after an earlier extraction or fracture.
- Surgery needed to cut into gums and tissues of the mouth when not done in connection with the removal or repair of teeth.
- Surgery needed to alter the jaw, jaw joints or bite relationships by a cutting procedure, when appliance therapy alone cannot result in *Functional Improvement*.
- Non-surgical treatment of infections or diseases, not including those of or related to the teeth.
- Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore or reposition natural teeth damaged, lost or removed or other body tissues of the mouth fractured or cut due to a non-occupational injury. The accident causing the injury must occur while the person is covered under this Plan. Any such teeth must have been free from decay or in good repair and firmly attached to the jaw bone at the time of the non-occupational injury. The treatment must be done in the calendar year of the accident or the next one.
- If crowns (caps), dentures (false teeth), bridgework, or in-mouth appliances are installed due to such injury, covered medical expenses include only charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.

The following Mouth, Jaw and Teeth expenses are <u>not</u> covered under the Medical Plan.

- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing.
- To repair, replace or restore fillings, crowns, dentures or bridgework.
- For non-surgical periodontal treatment.
- For scaling, planing, scraping, or cleaning.
- For myofunctional therapy (muscle training therapy or training to correct or control harmful habits).

- For appliances, crowns, bridgework, dentures, tooth restorations or any related fitting or adjustment services, except as provided for injury, whether or not the purpose of such services or supplies is to relieve pain.
- For root canal therapy.
- For routine tooth removal (not needing cutting of bone) except as provided in the event of an injury.

- Newborn care, including charges for circumcision, for up to 14 days of hospitalization (for continued hospitalization to be covered, the newborn must be added to the retiree's coverage as a dependent),
- Nursing Services

  The services of registered nurses are covered (subject to *medical necessity*); however, the Plan does not cover services which are primarily *custodial* in nature, or performed by a nurse who ordinarily resides in your home or who is a member of your family or your Spouse's family.
- Organ Transplant services – Transplant services for bone marrow, heart, kidney, liver, heart/lung, pancreas/kidney or lung organ transplants will be covered when medically appropriate and necessary. Other services covered when the organ transplant is performed are as follows:
  - The acquisition, preparation, storage and transportation of the donated organs, up to a maximum of $25,000 per transplant.
  - Transportation and living expenses for the organ transplant recipient who is a participant and family members to the transplant facility when the facility is located more than 75 miles from the residence, up to a maximum of $10,000 per transplant.
  - In the event the organ transplant recipient who is a participant must stay within the area of the facility and be medically monitored prior to the human transplant or after the transplant, the $10,000 referenced above can be used for this purpose, except the 75 mile limit does not apply.
- Pre-Admission Or Pre-Operative Testing – diagnostic lab and X-rays within five days before hospitalization
- Prostheses
- Physical therapy

  Charges are covered if prescribed by a physician, performed by a licensed physical therapist, and result in significant improvement of bodily function.
- Prosthetic appliances,
- Radiological services, such as X-ray services and MRI
- Rehabilitative services on an outpatient basis, including testing, physical therapy, occupational therapy, and speech therapy
- Sterilization for the retiree or Spouse only (sterilization reversal is not covered)
- Urgent care center services, excluding any related facility fees

- Support Stockings

  Support stockings are covered if prescribed by a physician and custom made to fit the measurements of the patient. Covered are the initial purchases and replacements (when no longer serviceable), up to a total of four pairs per year.

- Vision Care

  Vision care is provided under the medical plan only for treatment due to illness or injury. Routine vision exams and hardware are not covered. Surgery or other procedures to correct vision are not covered.

POST-EMPLOYMENT MEDICAL CONTRIBUTIONS

CONTRIBUTIONS IF RETIRED ON OR AFTER 56th BIRTHDAY

Effective April 1, 2003, retirees will contribute monthly to the cost of the Preferred Provider Plan plus Prescription Drug Plan or the Comprehensive Plan plus Prescription Drug Plan or Alternate Plan (if available) plus Prescription Drug Plan elected during their enrollment through pension deduction, or direct billing (when the pension is not adequate to cover the contribution) based on the following schedules.

Non-Medicare Eligible Retiree / Surviving Spouse	**PPO Plan**		**Alternative Plans**	
	Single	**Family**	**Single**	**Family**
4/1/2003 – 12/31/2003				
PPO	$100	$200		
Paramount			$125	$250
OSF			$125	$250
Kaiser			$125	$250
Pacificare			$125	$250
January 1, 2004 – December 31, 2004	TBA *	TBA *	TBA *	TBA *

*** TBA = To Be Announced prior to the annual enrollment period.**

Medicare Eligible Retiree / Surviving Spouse	**Comprehensive Plan**		**Alternative Plans**	
	Single	**Family**	**Single**	**Family**
4/1/2003 – 12/31/2003				
Comprehensive	$ 50	$100		
Paramount			$ 85	$170
OSF			$115	$230
Kaiser			$115	$230
January 1, 2004 – December 31, 2004	TBA *	TBA *	TBA *	TBA *

*** TBA = To Be Announced prior to the annual enrollment period.**

CONTRIBUTIONS IF RETIRED BEFORE AGE 56

Any employee who is less than age 56 and who is eligible for post employment health care benefits and retires from PNA (exclusive of Disability Retirement under the Hourly Employees Pension Plan) pays 100% of the premium for medical, and prescription drug benefit coverage until such retiree reaches age 60. Such retiree premium shall be adjusted on an annual basis based on any cost increases to the plan of benefits elected by such retiree.

MEDICARE REIMBURSEMENT (Retirees under age 65)

An employee who retires from the Company and is eligible for continuation of health care coverage (other than COBRA) will be reimbursed until age 65 in an amount not greater than the Medicare Part B premium provided such retiree is eligible for and subscribes to Medicare Part B insurance. The Medicare Part B reimbursement shall not exceed the following schedule:

Period	Maximum
4/01/03 through 12/31/04	$54.00

COMPANY COST LIMIT

The Company and Union agreed to a limit on the future annual rate of increase in per capita health care costs to be borne by the Company for retirees, surviving spouses and their eligible dependents. Beginning with 1993 as the base year, if the actual rate of increase in per capita costs is expected to exceed 4% in any year, contributions from participating retirees and surviving spouses, or corresponding reductions in benefit levels will be required in order to achieve the 4% limit on Company cost increases.

- For purposes of the above calculation, the per capita cost for individuals who are not Medicare eligible was $789 as of January 1, 2003.
- For purposes of the above calculation, the per capita cost for individuals who are Medicare eligible was $239 as of January 1, 2003.

The method for determining contributions will be:

- Per capita costs will be determined on a paid basis combining indemnity and PPO claims, HMO premiums, EPO claims, Prescription Drug claims and administrative fees. In addition, per capita costs will be determined separately for individuals under age 65 and those age 65 or older that are covered by Medicare.
- Annually, the Company will determine the actual aggregate cost of paid retiree health benefits net of any contributions for the twelve month period ending in December of the year preceding the year for which retiree contributions are to be set. Based on an actuarial assessment, the actual aggregate experience will be allocated to average per capita costs which will then be compared to the maximum company costs for the year based on the 4% annual rate of increase since 1993 and any excess will be the required retiree contributions or corresponding reductions in benefit levels for that year.
- The actual paid per capita costs for prior years will be compared to those previously projected for the purposes of setting retiree contributions to determine if there was any surplus or deficit in retiree contributions, the amount of the deficit will be added to any required contributions for the next year. These adjustments will only apply for one year and do not become a permanent part of

the contributions.

- Effective for claims paid on or after January 1, 2003, the actual paid per capita costs for prior years will be compared to those previously projected for the purposes of setting retiree contributions if there are was any surplus or deficit in retiree contributions. The amount of the deficit or surplus will be added to or subtracted from any required contributions for the next year. These adjustments will only apply for one year and do not become a permanent part of the contributions.

D. HEALTHCARE EXCLUSIONS

EXCLUDED SERVICES

Services that are excluded (not covered) under the healthcare Plan are the following:

- Any service excluded elsewhere in this Summary Plan Description
- Any service not specifically mentioned as a covered service
- Acupuncture, except when performed by a physician in connection with a covered surgery
- Ancillary Mental Health and Chemical Dependency services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services
- Ancillary services or non-medical counseling are not covered. This includes (but is not limited to): Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neuro-feedback, hypnosis, sleep therapy, employment counseling, and back to school training.
- Artificial aids, such as eyeglasses, frames, contact lenses, corsets, corrective orthopedic shoes, and arch supports
- Commission of a crime - services resulting from or arising from the patient's commission of a felony
- Treatment of congenital and\or organic disorders, including, but not limited to, organic brain disorder and Alzheimer's disorder, except for (i) stabilization of an acute episode of such disorder or (ii) management of medication
- Consultations by telephone, e-mail, and Internet, and telemedicine
- Cosmetics, dietary supplements and health and beauty aids
- Cosmetic Surgery and Therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomology or psychosocial complaints related to one's appearance. (However, reconstructive surgery required as the result of an accident or injury is covered limited to reasonable attempt(s) to regain, but not improve upon, the patient's original condition. Cosmetic surgery following a mastectomy is covered.)
- Counseling

- Any court-ordered diagnosis and/or treatment, including any diagnosis and/or treatment ordered as a condition of parole, probation or custody and/or visitation evaluation, except as such diagnosis and/or treatment is Medically Necessary
- Mental Health and Chemical Dependency Services, treatment and supplies primarily for rest, custodial, domiciliary or convalescent care
- Dental care
- Dental implants for any condition (except reconstruction following an accidental injury to sound natural teeth is covered).
- Devices or aids that assist with non-verbal communications, including communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books
- Diagnosis or treatment of pervasive developmental disorders, including, but not limited to, autism, learning disabilities, behavioral disabilities, devebpmental reading disorder, developmental arithmetic disorder of developmental articulation disorder
- Dietary aids and food supplements
- Durable medical equipment which is not Medically Necessary. Equipment also not covered:
  - Air conditioners, dehumidifiers, air purifiers, heat pads, hot water bottles, hot tubs, home enema equipment, saunas, bicycles, swimming pools, and
  - Other similar equipment and supplies that may be used as personal comfort items by an individual.
- Education therapy - charges for education therapy for learning disabilities, special education, or job training, whether or not the therapy is provided in a facility that provides mental health treatment.
- Employer provided services - services provided by the medical department or clinic of Pilkington, Pilkington North America or another employer.
- Charges for services that exceed applicable maximums in the Plan, such as annual and lifetime maximums or limits on days, visits, or episodes of care
- Experimental, investigational, or unproven procedures and drugs.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the third-party administrator's Medical Director to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or Sickness for which its use is proposed; or
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use; or
  - The subject of review or approval by an Institutional Review Board for the proposed use, or
  - The subject of an ongoing phase I, II or III clinical trial.

- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary
- Services or supplies provided free of charge and/or services and supplies that are normally obtained by individuals without cost.
- Routine genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Government services - services related to a condition connected to military service provided to patients in any veterans, marine, federal, or other government hospital or through any government agency.
- Home health care (except as previously specified)

  The plan does not cover the following home health care expenses (may be covered under hospice):

  - Home health aide services
  - Services or supplies not specified in the treatment plan
  - Services of a social worker
  - 24-hour nursing care
  - Services excluded under hospice care services
- Hospital beds "reserved" for a patient
- Hospitalization for testing
- Immunizations (unless covered under the section entitled "Preventive Care")
- Legal services.
- Charges for services you are not legally required to pay
- Massage Therapy.
- Marriage counseling, except for the treatment of a Mental Health/Substance Abuse Condition
- Charges for services and supplies not Medically Necessary, as determined by the claims administrator, Plan Administrator, or utilization review administrator, for the diagnosis, care, or treatment of the physical or mental condition involved, even if prescribed and recommended by a physician.
- Medication (unless covered by the prescription drug program)
- Medication provided on an inpatient or outpatient basis that is given for homebound use (may be covered by the prescription drug plan)
- Mental health care and chemical dependency treatment (may be covered by the mental health and chemical dependency plan)
- Mental retardation counseling and services (other than initial diagnosis), and treatment of learning disabilities, developmental delays, and autism.

- Miscellaneous exclusions:
  - Care, treatment, services, or supplies that are not prescribed or recommended and approved by a licensed Physician.
  - Mileage costs, sales tax, missed appointments, completion of claim forms, preparation of medical records, or further documentation needed by the claims administrator
  - Nutritional supplements and formulae are excluded except for infant formula needed for the treatment of inborn errors of metabolism.
  - Psychological examination, testing or treatment for purposes of satisfying an employer's, prospective employer's or other party's requirements for obtaining employment, licensing or insurance, or for the purposes of judicial or administrative proceedings (including but not limited to parole or probation proceedings);
  - Return to work services, work hardening programs, driving safety, and services, training, educational therapy or other non-medical ancillary services for learning.
  - Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance is not covered, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Services related to narcotic maintenance therapy in which an agonist, antagonist, or agonist/antagonist drug is used for chronic administration, as well as detoxification services related to such chronic drug maintenance use;
- Non-emergency weekend admission, unless surgery is being performed the next day and the weekend admission is medically necessary because of the condition of the patient (travel and convenience are not valid reasons)
- Obesity. Excluded are medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

  The following are specifically excluded:
  - Medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity;
  - Weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision, and
  - Behavior modification or other treatment of obesity or weight reduction, including surgery and supplies.
- Treatment of pain, except for Medically Necessary treatment of pain;
- Diagnosis and treatment for personal growth and/or development or in conjunction with professional certification;

- Charges for personal hygiene and convenience items Mental health and chemical dependency private hospital rooms and/or private duty nursing, unless determined to be Medically Necessary;
- Routine physical exams (except as noted under the section entitled preventive care)
- Pregnancy of a dependent child, including coverage for the newborn infant
- Private duty nursing, whether provided in a hospital or in a home
- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Substance Abuse Condition;
- Charges for services a school system is required to provide under law
- Services provided by the patient's Spouse, child, brother, sister, parents, in-laws, or someone living in the patient's home
- Services for sexual dysfunction, sex change, and counseling for gender identity or inadequacies are not covered. This includes any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction. Examples of uncovered treatments and supplies are (but are not limited to) treatment of erectile dysfunction, penile implants, anorgasmia, and premature ejaculation.
- Sex therapy, treatment for sexual deviance or diagnosis or treatment in conjunction with sexual reassignment procedures;
- Charges for smoking-deterrent programs and supplies (Except, the prescription drug program will cover a "once per lifetime" federal legend smoking deterrent treatment. The once per lifetime coverage must be a continuous program as indicated by the medication brochure and prescribed by a medical doctor or doctor of osteopathic medicine.)
- Stress management therapy
- Transplant of or implantation of non-human, artificial, or mechanical organs
- Convenience transportation charges for an ambulette, volunteer ambulance transportation, chair-mobile, or taxi
- Travel, whether or not recommended by a physician (except as specified under the organ transplant program)
- Services, treatment or supplies by a hospital owned or operated by the U.S. government if the charges are directly related to a sickness or injury related to military service
- Untimely claims - services for which a claim is not made within the time limits provided by the Plan
- Vaccines for infectious diseases (unless covered under the section entitled "Preventive Care")
- Vision correction, including radial keratotomy, laser, lasik, or any other service intended to correct vision (unless that service is rendered due to accident or illness, and does not improve upon the patient's original condition).
- Charges for services related to an illness or injury due to any act of war, declared or undeclared
- Worker's compensation

- Services in connection with any condition for which a person has received or is entitled to receive any benefit under Workers' Compensation or Occupational Disease Laws or similar laws.
- Services, treatment or supplies provided as a result of any worker's compensation or similar law, or obtained through, or required by, any governmental agency or program, whether federal, state or any subdivision thereof (exclusive of Medi-Cal) or caused by the conduct or omission of a third-party for which the Member has a claim for damages or relief, unless the Participant provides the Company's claims administrator with a lien against such claim for damages or relief.

ADDITIONAL EXCLUDED PROCEDURES

The following procedures and related services and supplies are also excluded from coverage regardless of clinical indications:

- Abdominoplasty
- Acupressure
- Applied kinesiology
- Blepharoplasty
- Craniosacral/cranial therapy
- Dance therapy, movement therapy
- Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions
- Macromastia or Gynecomastia surgeries
- Orthognathic Surgeries
- Panniculectomy
- Prolotherapy
- Redundant skin surgery
- Reversal of male and female voluntary sterilization procedures
- Rhinoplasty
- Rolfing
- Skin tag removal
- Temporomandibular jaw treatment (TMJ).
- Varicose vein surgeries

E. FEDERAL RIGHTS AND PLAN INFORMATION

ERISA RIGHTS

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 shall be entitled to:

- Receive information about your Plan and benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements (if any), 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 Pension and Welfare Benefit Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of his or her summary annual report.
- Continue health care coverage for yourself, spouse, or dependent 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 this coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- 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 coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, your next employer may subject you to a preexisting 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 this 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 (if applicable), 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 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 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 which 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 of a decision

concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

If it should happen that the 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, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in you telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

OTHER FEDERAL REQUIREMENTS

A number of federal laws have been enacted to protect and clarify the rights of participants in healthcare plans. Among these laws was the Employee Retirement Income Security Act of 1974 (ERISA), which was enacted to protect the rights of participants in pension and welfare group benefit plans in the U.S. This section provides information about certain amendments to ERISA that were enacted as part of The Health Insurance Portability Accountability Act of 1996 (HIPAA), The Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) and the Women's Health and Cancer Rights Act of 1998 (Women's Health Act). It also provides information concerning optional continuation of coverage as provided for by The Consolidated Omnibus Budget Reconciliation Act of 1985.

The requirements of these laws or amendments to laws are addressed in the following sections:

- Certification Of Health Care Coverage
- Claims Appeals Procedures
- Confidentiality Of Personal Health Information
- Continuation Of Coverage (COBRA)
- Material Reductions in Covered Services or Benefits
- Maternity Hospital Stay
- Re-Constructive Surgery Following Mastectomy

(In addition, there is also information on the Pilkington North America Healthcare Program and its component plans in the section entitled "PLAN INFORMATION".)

CERTIFICATION OF HEALTH CARE COVERAGE

If your Health Care Program coverage ends or your COBRA continuation coverage begins, the Plan Administrator (or designee) will provide you with written certification stating the period of your coverage. You may need to provide this certification if medical advice, diagnosis, care, or treatment was recommended or received for a condition you had within the six-month period before you enrolled in the new plan. If you become covered under another group health plan, check with that plan's administrator to see if you need to provide certification of prior coverage under the Health Care Program.

You may request copies of the certification for up to two years after your coverage ends by contacting the PNA Benefits Center at 1-800-685-4335.

CLAIMS and APPEALS PROCEDURES

Following are the claims procedures which are part of the Pilkington North America Health and Welfare Program (the Program) effective April 1, 2003. This notice is given to all participants in the Program as required by the federal law known as the Employee Retirement Income Security Act ("ERISA").

The healthcare procedures shown in the following section apply to medical and prescription drug claims filed after December 31, 2002 with CIGNA HealthCare, Medco Health Solutions, Paramount, and UniCare. Claims Administrators for the various health care plans are shown in the section entitled "PLAN INFORMATION".

Please note: other carriers are not automatically subject to these rules, but may be and may also or instead be subject to the rules of the group insurance governing body in the state in which they do business. Please contact these health providers directly if you have a question about their claim procedures.

If you have any questions, please call the PNA Benefits Center at (800) 685-4335. Representatives are available Monday through Friday (except holidays) from 8 am to 5 pm eastern time. You may also write to us at the following address:

Pilkington North America, Inc.
Benefits Center
P.O. Box 925
Toledo, OH 43697-0925

CLAIMS DISCLOSURE NOTICE REQUIRED BY ERISA

Submitting a Healthcare Claim

Initial claims for benefits are made to the Claims Administrator. The Claims Administrator for each plan is specified in Exhibit B. You or your authorized representative may file claims for benefits.

Claims must be filed using a written form supplied by the Claims Administrator and may be submitted by U.S. Mail, hand delivery, facsimile, or as an attachment to electronic mail. Telephone submissions using a toll-free telephone number provided by the Claims Administrator will be processed conditionally, subject to later receipt of the required forms by any of the delivery methods described in the preceding sentence.

Designating an Authorized Representative

You may file a claim by yourself, or you may designate another person to act on your behalf as your "authorized representative." To designate an authorized representative, you must notify the Claims Administrator in writing.

However, in the case of a claim involving urgent care, a health care professional (for example, a treating physician) who has knowledge of your medical condition will be permitted to act as your authorized representative without a written designation. This exception is intended to enable a health care professional to pursue a claim on your behalf under circumstances where, for example, you are unable to act by yourself.

Your authorized representative may act on your behalf by pursuing a benefit claim or appealing an adverse benefit determination. If you have an authorized representative, all notices will be provided to you through your authorized representative.

Types of Claims

How or when you file a claim for benefits depends on the type of claim it is. There are four types of claims, as follows:

- **Urgent Care Claims** A claim involving urgent care is a claim for medical care or treatment that the Claims Administrator must process on an expedited basis because your life, health or ability to regain maximum function are otherwise in jeopardy. Your claim is also considered "urgent" if a physician with knowledge of your medical condition either considers your claim to be an urgent claim or believes that you would otherwise be subject to severe pain that could not be adequately managed without the care or treatment that you are seeking

- **Pre-Service Claims.** Pre-service claims are claims for which you must ask for approval in advance of obtaining medical care in order for a benefit to be paid to you.

- **Post-Service Claims.** Post-service claims are claims that are not pre-service claims. Post-service claims are claims for payment for medical services that do not require prior approval.

- **Concurrent Care Claims** Concurrent care claims are claims that change previously approved initial claims. This would occur if you desire to extend a previously approved course of treatment by either increasing the number of treatments or the period of time for treatments. Similarly, a decision may be made by the Claims Administrator to reduce or terminate a previously approved course of treatment.

Time Limits for Filing Initial Claims

You may submit a claim for benefits up to 18 months after the date of service. (For example, if you or your dependent obtains a medical service on a certain date, you have until 18 months after that date to submit this medical claim to the Claim Administrator for payment.)

Deadline for Initial Claim Decision

If you claim a right to benefits and the Claims Administrator does not request additional information to process the claim, you will be informed of the decision by the Claims Administrator as soon as possible under the medical circumstances, but not later than the following deadlines:

- **Urgent Care Claims** For urgent care claims, 72 hours after receiving your claim.

- **Pre-Service Claims** For pre-service claims, 15 days after receiving your claim. This 15-day period may be extended for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. You will be informed of an extension within the initial 15-day period. The extension notice will state the circumstances requiring the extension and the date by which a decision is expected.

- **Post-Service Claims** For post-service claims, 30 days after receiving your claim. This 30-day period may be extended for an additional 15 days if the extension is required due to matters beyond the Claims Administrator's control. You will be informed of an extension within the initial 30-day period. The extension notice will state the circumstances requiring the extension and the date by which a decision is expected. If you have a post-service claim, you will only be notified of a decision if the claim is denied in whole or in part.

- **Concurrent Care Claims** If you want to extend a previous course of treatment and your new claim is an urgent claim, then the following rules apply.

- If your claim is made at least 24 hours before your original treatment would expire, you will be provided with a notification of a decision within 24 hours after the receipt of your claim.

- If your claim is not made at least 24 hours before your original treatment would expire, your claim will be treated like an urgent care claim or a non-urgent care claim, depending on the circumstances.

If you want to extend a previous course of treatment and your new claim is not an "urgent" one, your claim will be treated like a pre-service claim or a post-service claim, as applicable

If the Claims Administrator determines that your current course of approved treatment should be reduced or terminated (other than, for example, the Company revising the coverage under a plan to reduce or terminate particular coverages), you will be treated as having received an adverse benefit determination. You will be provided with sufficient advance notice of the reduction or termination to allow you to appeal and obtain a determination before the benefit is reduced or terminated.

If the Claims Administrator Requests Additional Information

The Claims Administrator will contact you if you have not complied with the filing procedures; provided that: (1) the claim is received by the Claims Administrator, (2) the claim names a specific claimant, medical condition and treatment (or service) for which approval is requested, and (3) the Plan Administrator and Claim Administrator have your current address and/or phone number.
Also, the Claims Administrator will contact you if it wants additional information to process your claim. If additional information is requested, the deadlines for the determination are extended.

Urgent Care Claims

You will be notified within 24 hours after receipt of the claim if your claim does not comply with the applicable plan's filing procedures and, at that time, will be advised of the proper filing procedures.

If the Claims Administrator wants additional information to evaluate your claim, you will be notified within 24 hours after receipt of the claim. You will have a "response period" of 48 hours to respond to this request and will be informed of the decision within 48 hours of either (1) the end of this response period or (2) the Claims Administrator's receipt of the additional information, if earlier.

Pre-Service Claims

You will be notified within 5 days after receipt of your claim if your claim does not comply with the plan's filing procedures and, at that time, will be advised of the proper filing procedures.
You will be notified if the Claims Administrator wants additional information to evaluate your claim. You will have a "response period" of 45 days to respond to this request. The deadline for the decision to be rendered will not include the period of time beginning on the date you are requested to provide additional information and ending on the earlier of the date you provide the information or the end of the response period.

Post-Service Claims

You will be notified if the Claims Administrator wants additional information to evaluate your claim. You will have a "response period" of 45 days to respond to this request. The deadline for the decision to be rendered will not include the period of time beginning on the date you are requested to provide additional information and ending on the earlier of the date you provide the information or the end of the response period.

If Your Claim is Denied

You will be notified in writing or electronically if your claim is denied in whole or in part. The notice will tell you the specific reason(s) for the decision, the specific plan provisions on which the determination is based, the additional material or information necessary to perfect your claim and why that material or information is necessary, as well as additional information required by Department of Labor Regulations 2560.503-1(g).

The Appeals Process

In general, the Plan Administrator (as shown on the following page) has delegated to the Claims Administrator the obligation of deciding appeals. Unless you are advised differently in the notice denying your initial claim, your appeal of the decision should be made to the Claims Administrator.

You must appeal the partial or total denial of your claim in writing, unless your claim involves urgent care, in which case the appeal may be requested orally.

- **Urgent Care Claims.** You may appeal the decision within 180 days of receiving the notification. There is an expedited review process for urgent care claims. All necessary information, including the decision on review, may be transmitted by telephone, facsimile, or other available similarly expeditious method.

- **Pre-Service Claims and Post-Service Claims.** You may appeal the decision within 180 days of receiving the notification.

- **Concurrent Care Claims.** If your appeal relates to your attempt to extend a current course of approved treatment, the deadline to appeal will depend on whether your claim for an extension is considered to be an urgent, pre-service, or post-service claim.

If the Claims Administrator decides to reduce or terminate your ongoing treatment, you will be provided with sufficient advance notice of the reduction or termination to allow you to appeal and obtain a determination before the treatment is reduced or terminated.

Notification of Appeal Determination by Claim Administrator

You will be notified of the determination on the appeal as soon as possible under the medical circumstances, but not later than the following:

- **Urgent Care Claims**
  - In cases where you may only appeal once, 72 hours after your request for review is received.
  - In cases where there are two levels of appeal and there was an adverse determination at one or both levels, the period for completing each review will not exceed 72 hours.

- **Pre-Service Claims**
  - In cases where you may only appeal once, 30 days after your request for review is received.
  - In cases where there are two levels of appeal, 15 days after your request for review is received at each appeal level.

- **Post-Service Claims**
  In cases where you may only appeal once, 60 days after your request for review is received. In cases where there are two levels of appeal, 30 days after your request for review received at each appeal level.

- **Concurrent Care Claims**
  If your appeal relates to your attempt to extend a current course of approved treatment, the deadline for a decision on appeal will depend on whether your claim for an extension is considered to be an urgent, pre-service, or post-service claim. If the Claims Administrator decides to reduce or terminate your ongoing treatment, you will be notified of the decision on appeal before the benefit is reduced or terminated.

- **Rights Upon Appeal**
  In connection with your right to appeal an adverse determination regarding your claim, you:
  - May submit written comments, documents, records, and other information relating to the claim for benefits;
  - May request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
  - Will receive a review of the determination that takes into account all comments, documents, records, and other information that you submit relating to the claim, without regard to whether this information was submitted or considered in the initial benefit determination;
  - Will receive a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor his or her subordinate;
  - Will be provided, upon request, with the identification of the medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - Will receive a review in which the appropriate named fiduciary shall consult with a health care professional who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual, and who has appropriate training and experience in the field of medicine involved in the medical judgment of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate.

If Your Appeal is Denied.

If your appeal is denied, the Claim Administrator will provide you with written or electronic notification of the determination. The notification will tell you the specific reason(s) for the adverse determination, the specific plan provisions on which the benefit determination is based, that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits, a statement describing any additional appeal procedures offered by the plan and your right to obtain the information about those procedures, and a statement of your right to bring an action under section 502(a) of ERISA, as well as additional information required by Department of Labor Regulations 2560.503-1(j).

If your claim involves urgent care, the notice may be provided orally to you within the time frames for urgent care claims described in the section entitled "Deadline for Initial Claim Decision." A written or electronic notice will be furnished to you within 3 days after the oral notice.

Second Level Appeal

If you are covered under a self-insured plan (currently CIGNA, Medco Health Solutions, Paramount, and UniCare), and you have exercised all your rights of appeal through the Claim Administrator, and your claim is denied as a result of that process, you may file a second level appeal with the Plan

Administrator of the Program. The second level appeal is generally subject to the rules governing the first appeal, except that it should be submitted to the Plan Administrator, and it must be received within 180 days after you are notified by the Claim Administrator of the decision relating to your first appeal.

The Plan Administrator for the Pilkington North America Health and Welfare Program is the Welfare Plans Committee. Appeals to the Plan Administrator should be sent to:

Pilkington North America
Welfare Plans Committee
P.O. Box 925
Toledo, Ohio 43697-0925

After your appeal is received, the decision made by the Claim Administrator will be reviewed by the Plan Administrator. Within 30 days after the Plan Administrator has received your appeal, the Plan Administrator will notify you in writing of the decision. If this final appeal is denied in whole or in part, the written notice will explain the reason for the adverse benefit determination and the plan provisions upon which the denial is based.

You may have representation throughout the entire appeal and review procedure.

CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires health plans to notify plan participants about its policies and practices to protect the confidentiality of their health information. The following enclosed document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the Pilkington North America Health Care Plan (the "Plan") as sponsored by Pilkington North America, Inc. (the "Company").

The Plan needs to create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy with respect to your Medical and Prescription Drug benefits. This notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your physician or other personal health care providers.

Pilkington North America's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan protects confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the payment of your health care expenses. This individually identifiable health information is known as "Protected Health Information" (PHI). Your Protected Health Information will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by federal and state health information privacy laws.

Privacy Obligations of the Plan

The Plan is required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information about You

The following are the different ways the Plan may use and disclose your Protected Health Information:

- **For Treatment**. The Plan may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the Plan may advise an emergency room physician about the types of prescription drugs you currently take.
- **For Payment.** The Plan may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.
- **For Health Care Operations**. The Plan may use and disclose your Protected Health Information to enable it to operate or operate more efficiently or make certain all of the Plan's participants receive their health benefits. For example, the Plan may use your Protected Health Information for case management or to perform population-based studies designed to reduce health care costs. In addition, the Plan may use or disclose your Protected Health Information to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The Plan may also combine health information about many Plan participants and disclose it to the Company in summary fashion so it can decide what coverages the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Company so it may be sued without the Company learning the identity of specific participants.
- **To the Company**. The Plan may disclose your Protected Health Information to designated Company personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures will be made only to the Company's Welfare Plans Committee of the Company's Health Care Program ("the Plan Administrator"), the secretary for the Plan Administrator, the Manager of Benefits Administration, and/or the members of the Company's Benefits Department. These individuals will protect the privacy of the Protected Health Information and ensure it is used only as described in this notice or as permitted by law.

  Unless authorized by you in writing, your health information: (1) may not be disclosed by the Plan to any other Company employee or department and (2) will not be used by the Company for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Company.

- **To a Business Associate.** Certain services are provided to the Plan by third party administrators known as "business associates". For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In so doing, the Plan will disclose your Protected Health Information to its business associate so it can perform its claims payment function. However, the Plan will require its business associates to appropriately safeguard your health information.

- **Treatment Alternatives**. The Plan may use and disclose your Protected Health Information to tell you about possible treatment options or alternatives that may be of interest to you.

- **Health-related Benefits and Services.** The Plan may use and disclose your Protected Health Information to tell you about health-related benefits or services that may be of interest to you.

- **Individual Involved in Your Care or Payment of Your Care.** The Plan may disclose Protected Health Information to a close friend or family member involved in or who helps pay for your health care. The Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

- **As Required by Law**. The Plan will disclose your PHI when required to do so by federal, state, or local law, including those that require the reporting of certain types of wounds or physical injuries.

Special Use and Disclosure Situations
The Plan may also use or disclose your Protected Health Information under the following circumstances:

- **Lawsuits and Disputes**. If you become involved in a lawsuit or other legal action, the Plan may disclose your Protected Health Information in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.
- **Law Enforcement.** The Plan may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.
- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws or other similar programs.
- **Military and Veterans.** If you are or become a member of the United States armed forces, the Plan may release Protected Health Information about you as deemed necessary by military command authorities.
- **To Avert Serious Threat to Health or Safety.** The Plan may use and disclose your Protected Health Information when necessary to prevent a serious threat to your health and safety, or to the health and safety of the public or another person.
- **Public Health Risks.** The Plan may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability;

reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

- **Health Oversight Activities.** The Plan may disclose your Protected Health Information to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs.
- **Research**. Under certain circumstances, the Plan may use and disclose your Protected Health Information for medical research purposes.
- **National Security, Intelligence Activities, and Protective Services.** The Plan may release your Protected Health Information to authorized federal officials: (1) for intelligence, counter-intelligence, and other national security activities authorized by law and (2) to enable them to provide protection to the members of the U.S. Government or foreign heads of state, or to conduct special investigations.
- **Organ and Tissue Donation.** If you are an organ donor, the Plan may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.
- **Coroners, Medical Examiners, and Funerals Directors.** The Plan may release your Protected Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The Plan may also release your Protected Health Information to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you are as follows:

- **Right to Inspect and Copy.** You have the right to inspect and copy your Protected Health Information. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes.

  To inspect and copy health information maintained by the Plan, submit your request in writing to the Plan Administrator. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

- **Right to Amend.** If you feel that health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment of your Protected Health Information for as long as the information is kept by or for the Plan.

  To request an amendment, send a detailed request in writing to the Plan Administrator. You must provide the reason(s) to support your request. The Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and copy.

- **Right to an Accounting of Disclosures**. You have the right to request an "accounting of disclosures." This is a list of disclosures of your Protected Health Information that the Plan has made to others, except for those disclosures necessary to carry out health care treatment, payment, or operations; disclosures made to you, or in certain other situations.

  To request an accounting of disclosures, submit your request in writing to the Plan Administrator. Your request must state a time period, which may not be longer than six years prior to the date the accounting was requested.

- **Right to Request Restrictions**. You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example you could ask that the Plan not use or disclose information about a surgery you had.
  To request restrictions, make your request in writing to the Plan Administrator. You must advise us on: (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

  Note: ***The Plan is not required to agree to your request.***

- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan send your Explanation of Benefits (EOB) forms about your benefit claims to a specified address.

  To request confidential communications, make your request in writing to the Plan Administrator. The Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of this Notice**. You have the right to a copy of this notice. You may write to the Plan Administrator to request a written copy of this notice at any time.

Changes to this Confidentiality Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future. The Plan will post a copy of the current notice in the Company's Benefits Office at all times.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Plan Administrator at the address listed below. Alternatively, you may complain to the Secretary of the U.S. Department of Health and Human Services, generally within 180 days of when the act or omission complained of occurred.

Note: *You will not be penalized nor will there be any retaliation against you for filing a complaint.*

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the Plan will be made only with your written authorization. If you authorized the Plan to use or disclose your Protected Health Information, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclosure your PHI for the reasons covered by your written authorization. However, the Plan will not reverse any uses or disclosures already made in reliance on your prior authorization.

Contact Information

If you have any questions about this notice, please contact:

The Pilkington North America Healthcare Plan Administrator
Pilkington North America
Benefits Department
811 Madison Ave.
P.O. Box 925
Toledo, OH 43697-0925

Phone: (800) 685-4335

CONTINUATION OF COVERAGE UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 ("COBRA")

Through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and your eligible family members have the right to continue health care coverage if you would otherwise lose coverage because of what is known as a "qualifying event." You or your covered dependent may continue coverage if you or your dependent notify the Company within 60 days of a qualifying event.

The list of "qualifying events" and detailed information on your rights under COBRA may be found at the end of this section under the **MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS.**

The following chart shows the general periods of eligibility for COBRA continuation coverage.

If coverage ends because…….	You may continue coverage For you and your dependents for up to……	Each covered dependent may continue coverage for up to……
You stop working for the Company (for reasons other than gross misconduct).	18 months[1] from the date of the qualifying event	18 months[1, 2] from the date of the qualifying event
Your working hours are reduced to less than benefit-eligible status.	18 months[1] from the date of the qualifying event	18 months[1, 2] from the date of the qualifying event
You die.	N/A	36 months from the date of the qualifying event
Your covered dependent is no longer eligible for coverage.	N/A	36 months from the date of the Qualifying event

[1] If the Social Security Administration determines that you or any of your covered dependents were disabled at any time during the first 60 days of COBRA coverage (beginning on the day after your termination of employment or reduction in hours), you or any of your covered dependents (regardless of which person is disabled) may request an extension of COBRA continuation coverage of up to 11 additional months (for a maximum total coverage period of 29 months). For coverage to be extended, the Plan Administrator must be notified of the disability determination no later than 60 days after the determination date and within the original 18-month COBRA period.

[2] If another qualifying event occurs during these 18 months, your dependent may choose to continue coverage for another 18 months after the date of the new qualifying event. However, the total continuing coverage period cannot be longer than 36 months.

COBRA NOTIFICATION

The Company will notify participants who are eligible for COBRA coverage if you or your dependents become eligible for COBRA continuation coverage because of your death, termination, reduction in hours of employment, or ordinary Medicare entitlement. Under the law, you or a family member is responsible for informing the PNA Benefits Center at (800) 685-4335 if a Spouse or dependent becomes eligible for COBRA continuation coverage because of divorce, legal separation, or a child's losing dependent status. Notification must be made within 60 days of the event.

COBRA ENROLLMENT

Once the PNA Benefits Center is notified of a qualifying event, you will be notified of your right to choose COBRA continuation coverage, and information will be sent to you about the cost of coverage. If you want COBRA continuation coverage, you must choose it within 60 days after coverage has been terminated or the notification received, whichever is later, by completing an enrollment application.

The enrollment application will be mailed to you with the notification letter. You will then have 45 days from the date on the application to submit your check for the required premiums to avoid a gap

in coverage. If, while you are covered by COBRA, a child is born to you or placed for adoption with you, you may add the child to your coverage as a dependent with independent COBRA rights.

COBRA COVERAGE

The person receiving continuation coverage will be initially offered the identical coverage the person had immediately before the event causing loss of coverage. If you had elected family coverage, the person receiving continuation coverage may purchase single or family coverage. At later open enrollments, the person may choose any medical option available to similarly situated retirees or family members.

COST OF COBRA COVERAGE

You and/or your covered dependents must pay the full cost (100%) of COBRA continuation coverage, plus an additional 2% for administration (as provided by law), retroactive to the date coverage would otherwise have ended. COBRA premium payments are due monthly. The initial payment is due within 45 days after continuation coverage is elected. Later payments are due on the 5th of each month for coverage during that month.

WHEN COBRA CONTINUATION COVERAGE ENDS

COBRA continuation coverage ends on the last day of the month after the earliest of the following dates:

- The date the maximum coverage period ends,
- The date the person covered under COBRA fails to make the required contributions on time,
- The date the person covered under COBRA becomes covered under a new group plan (except when the other plan limits coverage because of the person's pre-existing condition),
- The date the person covered under COBRA becomes entitled to Medicare,
- The first day of the month that is at least 30 days after a disabled person is no longer disabled, as determined by the Social Security Administration, or
- The date the COMPANY Health Care Program is terminated.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under The Pilkington North America Healthcare Program (the *Plan*). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available

to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are the spouse of a retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because if the child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Pilkington North America, Inc., and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the retiree, commencement of a proceeding in bankruptcy (with respect to the employer), or the retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to:

Pilkington North America Benefits Center
P.O. Box 925
Toledo, Ohio 43697-0925

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the retiree, the retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

You must make sure the Plan's COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.

This notice should be sent to:

Ceridian CobraServe
National Service Center
P.O. Box 534123
St. Petersburg, Florida 33747-4123

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

In such cases, you must make sure that the Plan's COBRA Administrator is notified of the second qualifying event with 60 days of the qualifying event. This notice must be sent to:

Ceridian CobraServe
National Service Center
P.O. Box 534123
St. Petersburg, Florida 33747-4123

Please include documentation of the change. For instance, in the event of a divorce or legal separation, include copies of the court order or court entry.

If You Have Questions about COBRA

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. Questions about your COBRA continuation coverage should be directed to the Pilkington North America Benefits Center at (800) 685-4335, or Ceridian COBRA at (800) 877-7994. COBRA complaints and appeals may also be faxed to (727) 865-3648 or mailed to:

Ceridian COBRA Operations
Attention: Compliance Department
3201 34th St. South
St. Petersburg, FL 33711-3828

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or see the EBSA website at **www.dol.gov/ebsa** . Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA website.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information:

Pilkington North America Benefits Center
P.O. Box 925
Toledo, Ohio 43697-0925

MATERIAL REDUCTIONS IN COVERED SERVICES OR BENEFITS

If there is a material reduction in the covered services or benefits of the Health Care Program, you will be notified within 60 days after the adoption of the modification. Material reductions generally include any plan modification or change that:

- Eliminates benefits payable.
- Reduces benefits payable, including a reduction that occurs as a result of a change in formulas, methodologies, or schedules that serve as the basis for making benefit determination.
- Increases deductibles, co-pays, or other amounts to be paid by a participant or beneficiary.
- Reduces the service area covered by a health maintenance organization.
- Establishes new conditions or requirements (for example, preauthorization requirements) to obtaining services or benefits.

MATERNITY HOSPITAL STAY

Group health plans offering group health coverage generally may not, under federal law restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section, or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMY

When a person covered for benefits under this plan document, who has had a mastectomy at any time, decides to have breast reconstruction, based on consultation between the attending Physician and the patient, the following benefits will be subject to the same coinsurance and deductibles which apply to other plan benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Treatment of physical complications in all stages of mastectomy, including lymphedema; and
- Mastectomy bras and external prostheses limited to the lowest cost alternative available that meets the patient's physical needs.

HEALTHCARE PLAN INFORMATION

Plan Names	Pilkington North America, Inc. Group Health Care Program, composed of the following sub-plans: - Medical Plan (which includes prescription drug and mental health and chemical dependency benefits)	
Employer	Pilkington North America, Inc. P.O. Box 799 Toledo, OH 43697-0799	(419) 247-3731 Employer ID #34-1506654
Plan Sponsor	Pilkington North America, Inc. P.O. Box 925 Toledo, OH 43697-0925	(800) 685-4335
Plan Administrator	Welfare Plans Committee Pilkington North America, Inc. P.O. Box 925 Toledo, OH 43697-0925	(800) 685-4335
Agent for Service of Legal Process (Legal process may also be served on the Plan Administrator or a Plan trustee)	Office of General Counsel Pilkington North America, Inc. P.O. Box 799 Toledo, OH 43697-0799	(419) 247-3731
Plan Year	Calendar year (January 1 through December 1)	

HEALTHCARE PLAN CONTACTS

Type of Plan	Welfare: medical, mental health and chemical dependency, and prescription drug	
Plan Number	504	
Financial Facts	Self-funded *	
Claims Administrators		
Comprehensive PPO Plan	CIGNA HealthCare	**Claims:** CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 **or** CIGNA HealthCare P.O. Box 182223 Chattanooga, TN 37422-7223 **Appeals** (Level One Member Appeal)**:** CIGNA HealthCare PO Box 188030 Chattanooga, TN 37422 **Appeals (Level two Member Appeal):** CIGNA HealthCare National Appeals Unit PO Box 37963 Charlotte, NC 28237-7963 **Contact information:** Member Services (800) 244-6224
Prescription Drug benefits	Medco Health	**Claims**: Medco Health Solutions Inc. P.O. Box 182050 Columbus, Ohio 43218-2050 **Initial appeals**: Medco Health Solutions Inc. P.O. Box 182050 Columbus, Ohio 43218-2050 Member Services (800) 417-1916 **Second levels appeals:** Pilkington North America Welfare Plans Committee 811 Madison Ave. P.O. 925 Toledo, OH 43697-0925 Benefits Center: (800) 685-4335

ALTERNATIVE HEALTH PLAN CONTACTS (HMOs or EPOs)

The provisions presented in this Summary Plan Description (e.g. eligibility, termination of coverage, COBRA, etc.) also apply to Alternative Health Plans, including those below.

Plan Sponsor – **Kaiser Permanente** Funding: insured	**Claim Appeals:** Kaiser Foundation Health Plan Claims Department P.O. Box 12923 Oakland, CA 94604-2923 **Contact information:** Member Services (800) 464-4000 (800) 390-3510
Plan Sponsor – **OSF Health Plan** Funding: insured	**Claim Appeals:** OSF Health Plans Claims Department P.O. Box 5128 Peoria, IL 61601-5128 **Contact information:** Member Services (800) 673-5222
Paramount * Funding: Non-Medicare: self-insured Medicare: insured	**Claims**: Paramount Health Care 1901 Indianwood Circle Maumee, Ohio 43537 **Claim Appeals:** Paramount Health Care P.O. Box 928 Toledo, Ohio 43697-0928 Attention: Appeals Coordinator **Contact information:** Member Services (800) 462-3589 (419) 887-2525 Appeals Coordinator (419) 887-2448

***** If the Plan is self-funded, this means that the Plan Sponsor pays for the claims out of its general assets without recourse to an insurance policy (in certain instances where claims, either individually or in the aggregate, exceed a certain extraordinary amount, the Plan Sponsor may seek reimbursement under an excess loss insurance policy).

F. ABOUT THIS SUMMARY PLAN DESCRIPTION

This Healthcare section explains the main features of your health care coverage – and is a Summary Plan Description (SPD), as defined by the Employee Retirement Income Security Act of 1974 (ERISA). You should review the information about your *ERISA* rights and the appeals procedure in the "FEDERAL LAW: NOTICES AND REQUIREMENTS" section of this handbook.

This SPD, which is effective January 1, 2004, describes the Company healthcare Plan as it applies to eligible retirees and surviving spouses of the Company and their covered dependents:

- Medical Plan benefits
- Mental Health and Chemical Dependency benefits
- Prescription Drug benefits

This SPD supersedes and replaces all previous materials you may have received about the Plans. Coverage under the Plans is not a guarantee of employment, nor is this SPD a promise to always provide these benefit plans.

G. PLAN TERMS AND CONDITIONS

Your actual benefits are determined by Plan documents (including insurance contracts and/or policies) that control the operation of the Plans. These documents may be changed or canceled at any time. All changes will be communicated in writing. If any Plans are discontinued, benefits will be paid for any charges incurred for covered expenses before that date.

None of the terms and conditions contained in the official Plan documents are changed by anything contained in this SPD. If there is a disagreement between this SPD and the Plan documents, the Plan documents will be the final authority. You should not rely on any *oral* explanation of the Plans or their provisions because the *written* terms of the Plans always govern.

If any provision is unclear or ambiguous, the Plan Administrator has the right to interpret the Plan and resolve the problem. If challenged in court, the Plan Administrator's decision will be upheld, unless found by a court of competent authority to be arbitrary and capricious.

Pilkington North America, Inc. reserves the right to modify, amend or terminate any or all of the benefits and other features of the benefits plans described in this booklet at any time in its sole discretion, subject to the provisions of any applicable collective bargaining agreement, any applicable statutory bargaining obligation, and federal law.

If you have questions regarding the Plans, call the PNA Benefits Administration Center at **(800) 685-4335** or in the Toledo area (**419) 247-4714**.

H. DEFINITIONS

ALTERNATIVE HEALTH PLANS

In some locations, *PPO*s, *HMOs*, *EPOs*, or other medical arrangements may be available. If you have chosen one of these alternative medical plans, the benefits available through that plan are not described in this booklet, however the PNA eligibility, enrollment and termination provisions do apply.

While their actual structures may vary, Preferred Provider Organizations (PPOs) generally offer medical services from a "preferred" network of health care providers on a fee-for-service basis; that is, payment is made based on the medical treatment received. Obtaining treatment within this network of preferred providers generally results in cost savings to both you (through reduced co-payments) and the COMPANY since the rates for these services are negotiated at a lower level in exchange for preferred utilization by employees and dependents.

A Health Maintenance Organization (HMO) or an Exclusive Provider Organization (EPO) provides health care generally only at designated facilities, and receives a fixed monthly fee from the Company. For Company authorized HMOs, the Company pays a fee equal to the cost of providing the Company Plan and the employee pays a contribution of the balance. An EPO is a self-insured HMO. The Company pays all costs and claims of an EPO, less any contribution made by the retiree.

Due to the wide variety of managed care systems, benefits obtained from such systems may not be the same as provided under the Company Plan described in this Booklet. However, the basic provisions shown in this SPD (e.g. eligibility, termination of coverage, dependent limiting age, COBRA, etc.) do apply to Company-sponsored PPOs, HMOs, and EPOs.

CLINICAL EFFICACY

Clinical efficacy means that the treatment satisfies the following:

- The treatment can be reasonably expected to improve survival, health, or function; alleviate symptoms; or stabilize a condition,
- Its use outweighs any potential harm, and
- It is generally and widely accepted by the medical community within the United States.

COINSURANCE

Coinsurance is a percentage of the covered network charge (or covered out of network total charge) which is your responsibility to pay to the healthcare provider. Coinsurance amounts (except for prescription drug coinsurance amounts) are applied toward your annual Out-of-Pocket Maximum.

COMMON ACCIDENT

If two or more covered members of your family are injured in the same accident, the covered expenses which result from the accident in the current calendar year will be combined and only one individual deductible charged against all such expenses, regardless of the number of family members injured.

COMPANY (or The Company)

Pilkington North America, Inc.

CONTINUED COVERAGE
Coverage provided beyond the time limit when coverage would otherwise end, for example, coverage provided to the dependents of a deceased retiree. See eligibility and termination sections for details.

CONVALESCENT FACILITY
An Institution (or a distinct part thereof) which meets fully all of the following requirements:

It is primarily engaged in and duly licensed to provide, on an inpatient basis, skilled nursing and physical restoration services for patients convalescing from an injury or disease, and

- It is under the full-time supervision of a physician or registered professional nurse, and
- It provides skilled nursing services on a 24-hour basis under the direction of a full- time registered professional nurse, with licensed nursing personnel on duty at all times, and
- It has in effect a utilization review plan for all of its patients, and
- It maintains a complete medical record on each patient.

In no event will the term "CONVALESCENT FACILITY" include an institution, or part thereof, which is used principally as a place for rest, a place for CUSTODIAL CARE, a place for educational care, a place for care of mental disorders (including, but not limited to drug addiction, alcoholism, and mental retardation) or a place for the aged.

CONVALESCENT PERIOD
A Convalescent Period is a period of consecutive days of confinement in a CONVALESCENT FACILITY up to a maximum of 120 days per disability.

CO-PAYMENT
A Co-payment is a fixed dollar amount that you pay directly to an in-network provider of a healthcare service. When a Co-payment applies, there is no deductible. Co-payments are not applied toward your annual Out-of-Pocket Maximum.

CUSTODIAL CARE
Care comprised of services and supplies, including room and board and other institutional services, which are provided to an individual, whether disabled or not, primarily to assist him or her in the activities of daily living. Such services and supplies are CUSTODIAL CARE, regardless of who provides, prescribes, recommends or performs them. Room and board and skilled nursing services, when provided to an individual in a HOSPITAL or other institution, for which coverage is specifically provided, shall not be considered CUSTODIAL CARE when such services must be combined with other necessary therapeutic services and supplies in accordance with generally accepted medical standards to establish a program of medical treatment which can reasonably be expected to contribute substantially to the improvement of the individual's medical condition.

DEDUCTIBLE
The amount you pay a year before the plan begins to pay benefits. Only eligible expenses are counted toward the deductible.

- INDIVIDUAL DEDUCTIBLE

  The deductible is the amount of eligible expenses which you pay before covered expenses are considered for payment by the Plan. The deductible applies only once in each calendar year. Any service subject to a fixed dollar co-payment is not subject to the deductible. Deductible amounts are applied toward your annual Out-of-Pocket Maximum.

- FAMILY DEDUCTIBLE

  When the combined deductible expenses for covered family members reach the amount of the Family Deductible in a calendar year, the deductible will be satisfied for all eligible family members. In no case will the combined deductible expenses incurred by a family exceed the amount of the Family Deductible for a calendar year. When the total of the INDIVIDUAL DEDUCTIBLES exceeds the FAMILY DEDUCTIBLE, the excess deductible will be paid to the retiree at the appropriate coinsurance rate.

EFFECTIVE TREATMENT

Effective treatment means a plan of treatment prescribed and supervised by a health care provider for a non-chronic condition that the treatment is reasonably expected to improve. Treatments solely for detoxification, for primarily providing an environment without access to alcohol or drugs, or for CUSTODIAL CARE are not considered effective treatments.

EVIDENCE OF INSURABILITY

Documentation in the form of an evidence statement, medical exam, or an attending physician's report used to evaluate the medical condition of an applicant for coverage under the PLAN.

EXCLUSIONS

Services and supplies that are not covered under the Medical Plan, Prescription Drug Plan, and Mental Health and Chemical Dependency Plan, regardless of the Medical Necessity of the service or supplies.

EXPERIMENTAL, INVESTIGATIONAL, OR UNPROVEN PROCEDURES or TREATMENTS

The Company Health Care Program defines an experimental, investigational, or unproven procedure or treatment as a drug, device, treatment, or procedure that, in the context of a particular case:

- Cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is provided, or
- Is not shown by widely accepted clinical efficacy to be effective in treating the condition, illness, or diagnosis for which its use is proposed, or
- Is the subject of clinical trials or study (or deemed by the majority of experts to require clinical trials or study).

FAMILY STATUS CHANGE

A Family Status Change is defined as the: marriage or divorce of the retiree, birth or adoption of a dependent, gain or loss of a dependent through legal custody proceedings, death of the retiree or the spouse or dependent of the retiree, divorce of the retiree, or gain or loss of employment by the Spouse

of the retiree, or loss of Medicare or Medicaid eligibility (but not if due to non-payment of Medicare or Medicaid premiums).

FUNCTIONAL IMPROVEMENT

Functional Improvement is the significant, measurable restoration or improvement of a physiological impairment.

HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Health care delivery systems or organizations which emphasize preventive health care and early treatment, as well as provide *Medically Necessary* care for illness and injury. HMO coverage differs in that you must receive services from HMO providers for the services to be covered. Unlike the PPO option, non-emergency services obtained from providers outside of the HMO panel are NOT covered at all unless the primary care physician makes the referral or the HMO authorizes treatment. The Company may offer Alternative Health Plans, including HMOs, at certain Company locations.

HOSPITAL

An institution which meets the following tests:

- It is primarily engaged in and duly licensed to provide, on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of physicians;
- It continuously provides 24-hour a day nursing service by registered graduate nurses; and
- It is not, other than incidentally, a place for rest; a place for the aged; a place for the cure of drug addiction, alcoholism, or other substance abuse; or a nursing home.

LIFE-THREATENING EMERGENCY

The sudden, unexpected change in a patient's physical condition with acute symptoms which are widely accepted professionally in the United States as severe enough to require immediate attention or care and without such immediate care would likely result in death.

MANAGED CARE PROGRAMS

Company authorized and approved Managed Care Programs may be available at certain Company locations. These are usually known as a Preferred Provider Organization (PPO'), Health Maintenance Organization (HMO'), or Exclusive Provider Organization (EPO).

While their actual structures may vary, PPOs generally offer medical services from a “preferred” network of health care providers on a fee-for-service basis; that is, payment is made based on the medical treatment received. Obtaining treatment within this network of preferred providers generally results in cost savings to both you (through reduced co-payments) and the COMPANY since the rates for these services are negotiated at a lower level in exchange for preferred utilization by retirees and dependents.

A Health Maintenance Organization (HMO) or an Exclusive Provider Organization (EPO) provide health care generally only at designated facilities, and receive a fixed monthly fee from the Company. For Company authorized HMOs, the Company pays a portion of the fee and the retiree pays the

balance. An EPO is a self-insured HMO. The Company pays all costs and claims of an EPO, less any contribution made by the retiree.

Due to the wide variety of managed care systems, benefits obtained from such systems may not be the same as provided under the Company Plan described in this Booklet. However, the basic provisions shown in this SPD (e.g. eligibility, termination of coverage, dependent limiting age, COBRA, etc.) do apply to Company-sponsored PPOs, HMOs, and EPOs.

MEDICALLY NECESSARY

The Company Health Care Program defines Medically Necessary care to be those services or supplies that are provided for the diagnosis or treatment of a condition, proper for the symptoms, diagnosis, or treatment of the condition, done in the proper settings or manner for the condition, and within the standards generally accepted by the medical community in the United States of America.

A service, treatment or supply must be generally accepted professionally as essential to the treatment of the disease or injury and lead to Functional Improvement. (Payment in cases of terminal illness is not precluded but may be limited to pain management.) Your physician has the responsibility to suggest or implement a course of treatment. However, for purposes of payment under this Plan, final determination of Medical Necessity is by the Third Party Administrator in conjunction with its medical professionals.

A service or supply is medically necessary only when it meets all of the following requirements:

- It must be legal,
- It must be ordered by a licensed physician,
- It must be necessary to treat the patient's condition,
- It can be reasonably assumed to be safe and effective in treating the condition for which it is ordered,
- It must be consistent with the diagnosis of and prescribed course of treatment for the patient's condition,
- Its clinical efficacy must be generally accepted by the U.S. medical community,
- It must be of the proper quantity, frequency, and duration for treatment of the condition for which it is ordered,
- It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered,
- It must not be an experimental, investigational, or unproven procedure,
- Its purpose must be to restore health and extend life,
- It must be required for reasons other than the convenience of the patient or physician, and
- It must be performed at the most cost-effective type of setting appropriate for the condition.

MENTAL HEALTH CARE

Services directed to the effective treatment of the emotional well-being of the individual, including counseling, counseling for members of the patient's family, group psychotherapeutic treatment, psychological testing, electroshock therapy (administered by a physician), and related anesthesia.

NON-OCCUPATIONAL DISEASE OR INJURY

A Non-occupational disease or injury is a disease or accidental bodily injury which does not arise out of, or in the course of, employment.

OUT OF POCKET LIMIT

Your out-of-pocket financial exposure for your share of covered Medically Necessary expenses (including deductibles) is limited to an annual amount per covered individual, or a maximum per family per calendar year. After either of these Out-of-Pocket Limits is met during a calendar year, the Company will pay 100% of subsequent covered Reasonable and Customary expenses for the remainder of that calendar year under the terms of the Plan.

Expenses that you and your eligible dependents may incur which are not recognized in reaching the out-of-pocket limits are as follows:

- Medical co-payments
- Prescription co-payments
- Prescription co-insurance
- Any medical procedure, goods or services which are not covered under the Comprehensive PPO Medical Plan, such as extra inpatient HOSPITAL days, diagnostic HOSPITAL admissions, charges over REASONABLE and CUSTOMARY, unnecessary tests or treatment, inpatient room and board if outpatient treatment would have been sufficient, etc.
- Employee contributions.

LIFETIME MAXIMUM

The Medical Plan will reimburse you and your covered dependents up to the Lifetime Maximum per person for all covered Medical Plan expenses.
If you have received payments totaling the Lifetime Maximum benefit, your enrolled dependents will still be covered. Similarly, if one or more of your dependents has received payment of the maximum benefit, coverage for you and your remaining enrolled dependents will continue. Persons who have reached the maximum benefit limit are not eligible for COBRA nor for any conversion coverage.

PARTICIPANT

An retiree, Spouse, or dependent of an retiree of the Company who is enrolled in this health care plan and whose coverage has not terminated.

PHYSICIAN

A medical professional licensed and in good standing to practice medicine as a Physician in the state where the healthcare service is rendered.

PLAN

The Pilkington North America Inc. Health and Welfare Plan

PLAN ADMINISTRATOR

Pilkington North America, Inc.

PREFERRED PROVIDER

A Hospital, Physician, laboratory, or other healthcare service provider who has contracted with the Company or Plan Administrator to provide health care services to Participants in the Plan at a discount.

PREFERRED PROVIDER ORGANIZATION

Under a Preferred Provider Organization arrangement, selected doctors, hospitals and other health care providers in a geographic area are pooled together to provide services to you and your family. Because they have agreed to participate under this arrangement, they can offer quality care on a cost-effective basis.

REASONABLE AND CUSTOMARY

The cost of a medical service will be considered to be Reasonable and Customary (R&C) when it is the lesser of:

- The charged fee,
- The usual charge for a covered service, taking into account charges by other providers with similar training and experience for the same service in the same geographic area, or
- The scheduled fee agreed to by the provider.

A fee is "REASONABLE" when it is the fee usually charged for a service or is justifiable when extraordinary circumstances of a particular case are considered. "CUSTOMARY" is when a fee is within the range of usual fees charged for the service by health service providers within the same specific and limited geographic area. To be covered, fees must be both REASONABLE and CUSTOMARY.

Fees in excess of REASONABLE and CUSTOMARY limits are the responsibility of the patient. If you want to question or contest the difference, it is your responsibility to obtain any additional information from the provider which could explain the higher fee and thus qualify for coverage.

In determining the extent to which charges qualify as R&C, due consideration will be given to the nature and severity of the injury or illness being treated, including any complications or unusual circumstances requiring additional time, skill, or expertise. However, the final determination as to amounts qualifying as R&C will be made by the Plan Administrator.

SPONSORED DEPENDENT

A *sponsored dependent* is person who is a dependent of an *retiree*, but who is not eligible to participate in this benefit plan.

SPOUSE

A spouse is a person who is married to a retiree eligible for coverage under the provisions of this SPD. Said marriage must be recognized as a legal and binding marriage under the laws of the United States of America, the state(s) in which the retiree and the Spouse live, and the state in which the retiree worked for the Company.

THIRD PARTY ADMINISTRATOR (TPA)

Participants in this benefits program may (at times designated by the Company, usually annually) choose one of the healthcare options available at their location. Depending on your work location, and the option you choose, the Third Party (Claims) Administrator will be one of the following:

HEALTHCARE OPTIONS	THIRD PARTY ADMINISTRATOR*
Comprehensive PPO Plan	CIGNA
Comprehensive Plan (for those Medicare-eligible)	CIGNA
Prescription drug benefits	Medco Health Solutions
Kaiser	Kaiser Permanente
OSF HMO / Medicare supplement	OSF Health Plans
Paramount EPO / Medicare supplement	Paramount

*CIGNA and Medco are available to all participating *retirees*. Other options depend on what the Company has made available at your work location.

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