
# PILKINGTON NORTH AMERICA, INC.

# HEALTH CARE
# SUMMARY PLAN DESCRIPTION

**for**

## UNITED STEELWORKERS of AMERICA, AFL-CIO, CLC
## Lathrop Local 418G and Ottawa Local 19G

PNABenefits

# Lathrop and Ottawa Hourly Employees
# HEALTHCARE SUMMARY PLAN DESCRIPTION

## A. INTRODUCTION TO YOUR HEALTH CARE BENEFITS

Pilkington North America is pleased to offer its employees and their eligible dependents high-quality, cost-effective health care benefits, including medical, mental health, prescription drug, dental and vision 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 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 *claim administrator* directly:

| PLAN or PROGRAM | *Claim Administrator* | Member Services | Web Site |
|---|---|---|---|
| Comprehensive PPO Medical Plan | CIGNA HealthCare | (800) 244-6224 | www.cigna.com |
| Prescription Drugs | Express Scripts, Inc. | (800) 417-1916 | www.express-scripts.com |
| Dental | CIGNA | (800) 244-6224 | www.CIGNA.com |
| Vision | United Healthcare Vision | (800) 638-3120 | www.myuhcvision.com |
| Pre-tax Health or Dependant Care Accounts | CONEXIS | (888) 279-8385 | http://mybenefits.conexis.com |
| Employee Assistance | CIGNA Behavioral Health | (888) 371-1125 | N/A |

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

### PNA BENEFITS 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
- Employee 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 your local Human Resources Department.

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 **https://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* or *EPOs* 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.

| CLAIMS ADMINISTRATOR | PHONE | WEB SITE |
|---|---|---|
| Kaiser HMO (Lathrop) | (800) 464-4000 | www.kaiserpermanente.org |
| Blue Cross Blue Shield of Illinois | (800) 828-3116 | www.bcbsil.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<br>P.O. Box 182223<br>Chattanooga, TN 37422-7223 |
| **PRESCRIPTION DRUG CLAIMS** | Express Scripts, Inc.<br>P.O. Box 14711<br>Lexington, KY 40512 |
| **DENTAL CLAIMS** | CIGNA<br>P.O. Box 188037<br>Chattanooga, TN 37422-8037 |
| **VISION CLAIMS** | United Healthcare Vision Claims Department<br>P.O. Box 30978<br>Salt Lake City, Utah 84130 |

| | |
|---|---|
| **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 claim administrator within 12 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.

## BENEFITS HIGHLIGHTS

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

- *Experimental, investigational*, or *unproven* procedures are not covered.
- Procedures not expected to lead to improvement are not covered.
- To be considered for coverage, all claims must be for *medically necessary* services or supplies.

The following chart shows the highlights of the benefits available through the Plan. It does not fully describe your benefit coverage. For additional details on these benefits, please consult the Plan document or contact your healthcare provider.

| | | IN NETWORK *** | OUT OF NETWORK *** |
|---|---|---|---|
| | **Deductible (Individual, Family)**<br>January 1, 2014 | $400 / $800 | $800 / $1,600 |
| | **Co-payment**<br>January 1, 2014 | Primary Care: $30<br>Specialists: $40 | Deductible / Co-insurance |
| | **Co-insurance**<br>**(100% after OOP max met)** | 90% after deductible | 70% after deductible |
| | **Out-of-Pocket Maximums**<br>**(Individual / Family)**<br>• Excludes pharmacy expenses and amounts over "usual and customary" | 2014 $2,200 / $4,400 | 2014 $4,400 / $8,800 |
| | **Lifetime Maximum** | None | |
| | | | |
| **PREVENTIVE** | **Preventive Care** | | |
| | **Adult**<br>Routine physical exams, including PSA | 100% | Not Covered |
| | Routine GYN exams, including routine PAP & Mammogram | 100% | Deductible / Co-insurance |
| | Routine colonoscopy | 100% | Deductible / Co-insurance |
| | Well child care | 100% | Not Covered |
| | Immunizations | 100% | Not Covered |
| | | | |
| **HOSPITAL** | **Hospital Services**<br>(Inpatient; Semi-private room and Board) | 90% after deductible | 70% after deductible |
| | **Medical/Surgical Services** | 90% after deductible | 70% after deductible |
| | **Diagnostic Services**<br>(Lab, X-Ray and other tests) | 90% after deductible | 70% after deductible |
| | **Inpatient Physical Rehabilitation** | 90% after deductible | 70% after deductible |
| | | | |
| **OUTPATIENT** | **Primary Care Physician and Specialist Physicians - Office Visits** | Physician Co-payment<br>No deductible | 70% after deductible |
| | **Surgical Care** | Deductible / Co-insurance | |
| | **Tests/Treatment in Diagnostic Facility** | Deductible / Co-insurance | |
| | **Tests/Treatment in Physician's Office** | Deductible / Co-insurance | |
| | **Laboratory tests / X-rays** | Deductible / Co-insurance | |
| | **Physical, Restorative Speech, and Occupational Therapies.** (Note: there is a separate Cardiac Therapy benefit schedule per contract.) | Physician Co-payment<br>No deductible | 70% after deductible |
| | | Up to 25 days per calendar year. (Cardiac therapy separate.) | |
| | **Radiation / Chemotherapy** | Deductible / Co-insurance | |
| | **Durable Medical Equipment** | Deductible / Co-insurance | |

| | | IN NETWORK ** | OUT OF NETWORK ** |
|---|---|---|---|
| MATERNITY | **Infertility Counseling, Testing and Treatment** | **Deductible / Co-insurance<br>$5,000 lifetime maximum** | |
| | **Prenatal / Postnatal Care** | Physician co-payment for initial visit, then Deductible / Co-insurance | Deductible / Co-insurance |
| | **Hospital care for mother and child** | **Deductible / Co-insurance** | |
| | | | |
| OTHER CARE | **Organ Transplants** | 90% after deductible (100% if LifeSource Network Provider) | 70% after deductible |
| | **Emergency Room Fee**<br>(if admitted, co-pay waived) | $100 co-payment *<br>(waived if admitted)* | |
| | **Urgent Care Facility** | $50 co-payment * | |
| | **Ambulance–Traditional, Air, Boat ** ** | Deductible / Co-insurance *<br>(waived if admitted) | |
| | **Skilled Nursing Facility** | Deductible / Co-insurance<br>Up to 100 days per calendar year | |
| | **Private Duty Nursing** | Deductible / Co-insurance<br>Up to 100 days per calendar year | |
| | **Home Health Care** | Deductible / Co-insurance<br>Up to 100 days per calendar year | |
| | **Chiropractic** | Physician co-payment * | **Deductible / Co-insurance** |
| | | Up to $1,000 per calendar year | |
| | **Hearing Aids** | • 100%. Maximum $3,100 per three calendar year period.<br>• Includes the hearing aid and initial testing and fitting<br>• Participants may access any discount programs provided by the claims administrator | |
| | **Allergy testing / Therapy** | Lesser of physician co-payment or actual charge | Deductible / Co-insurance |
| | **Hospice** | Covered 100% - no deductible | |
| | | | |
| | **Prescription Drug Program applicable to the negotiated plan as well as to any alternative plan**<br>• Formulary is ESI's National Preferred Formulary with PNA exclusions<br>• Mandatory Mail Order. (Two refills allowed at retail, then Mail Order thereafter.)<br>• Participants may appeal to ESI 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**: None<br><br>Retail – 30 days supply<br>Mail Order - 90 days supply<br><br>**Retail and Mail Order Coinsurance:** 80% | |

| | **Retail Co-insurance** | | **Mail Order Co-insurance** | |
|---|---|---|---|---|
| **Eff.** | **Minimum** | **Maximum** | **Minimum** | **Maximum** |
| **1-1-14** | $12 | $120 | $24 | $240 |

**Employee Contributions**
Employee contributions will be paid through pre-tax payroll deductions.

| | PERCENT OF TOTAL COST OF MEDICAL AND DRUGS | |
|---|---|---|
| **Effective Payroll Date** | **Preferred Provider Plan & Drugs** | **Alternative Health Plan & Drugs** |
| January 2, 2012 | 13% | 13% |
| January 1, 2013 | 13% | 13% |
| January 7, 2014 | 14% | 14% |

* **Not subject to the deductible.**
** **To be considered for coverage, all claims must be for medically necessary services or supplies.**

**Important notes:**

- **Annual deductibles, co-payments, co-insurance and out-of-pocket maximums**

  The Comprehensive Provider Plan has a single deductible and family deductible applicable to certain charges. Separate deductible amounts apply based on whether services are received in or outside of the preferred provider network. After the deductible (or co-payment) has been satisfied, the Plan pays a percentage of usual, reasonable and customary eligible expenses and the employee or eligible dependents 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. Separate out-of-pocket maximums apply for "in" or "out" of network services.

- This benefit chart is a summary only. It does not fully describe the benefit coverage. Additional details are available in the remainder of this Summary Plan description, from the vendor, in the contract and the plan documents.

## B. GENERAL INFORMATION

## ELIGIBILITY

EMPLOYEE

You are an eligible employee if you are an hourly employee of Pilkington North America, Inc. at the Company's Ottawa, Illinois Plant or Lathrop, California Plant who is covered by a collective bargaining agreement. All regular full-time employees and their dependents (if applicable), are eligible for medical and prescription drug coverage the first of the month following two full months of employment, not to exceed 90 days, provided the employee is actively employed on that date and has completed the enrollment process necessary to enroll in such programs. If the employee is not actively at work, coverage will be effective on the first of the month following the day the employee returns to work on a full-time basis.

EMPLOYEE'S SPOUSE AND DEPENDENT CHILDREN

If you enroll in an available healthcare program, you may also enroll your Spouse and eligible dependents under the plan. You will be required to provide a copy of your marriage certificate and/or your child's birth certificate and their social security cards.

Your eligible dependents are:

- Your Spouse (see Definitions),
- Your children who have a regular parent-child relationship with you and have not reached the end of the month in which their 26th birthday occurs.

  A "child" for purposes of this *Plan* is defined as follows:
  - A natural born child, legally adopted child or a child under court appointed guardianship provided the child is dependent upon the employee for support and maintenance. An adopted child can be considered a "child" from the moment the child is placed in the custody of the employee and his or her spouse; or
  - A stepchild, when the stepchild resides in the employee's household in a regular parent-child relationship and is principally dependent upon the employee for support and maintenance; or
  - Adult Children ages 19 to 26 whether or not they live with you; or
  - An employee's unmarried child beyond age 26 if, prior to attaining age 26, the child is:
    - incapable of self-sustaining employment by reason of mental retardation or physical disability, and
    - principally dependent upon the employee 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 will be the employee's responsibility to provide documentation to the Company of continued proof of incapacity upon request.

ADDITIONAL DEPENDENT ELIGIBILITY RULES

- An eligible Child of any age up to age 26:
  - does not have to be a student.
  - may be married. (See further rules below.)
  - must be enrolled in the same medical plan as chosen by the employee.
  - will be covered until the earlier of
    - The end of the month in which the child reaches age 26, or
    - The end of the month in which there is any occurrence specified in the section "When Health Coverage Ends" later in this Summary Plan Description.

- **Children ages 19 to age 23 must provide proof of full time student status at an accredited school, college or university to be eligible for the PNA Dental Plan and for the PNA Vision Plan.** Such student will be covered for dental and vision coverage until the earlier of:
  - The end of the month in which the child reaches age 23 or
  - The end of the month three months after the date the child graduates, or
  - The end of the month in which a child stops being a full-time student.

The plan Administrator may from time to time require evidence of the child's full-time student status. A copy of your child's current class schedule which must include the student's name, school name and number of full-time credit hours or a letter from the institution must be provided when requested. If a dependent loses dental/vision coverage due to failure to maintain full-time student status and has not reached the limiting age noted above, the dependent may have coverage reinstated the first of the month following the date proof of return to full-time student status is provided to the PNA Benefits Center.

A covered student who loses full-time student status due to a Medically Necessary Leave of Absence from school may continue to be covered under the dental/vision Plan for up to the earlier of a) reaching age 23 or b) one year after the date coverage would otherwise have ended. A Medically Necessary Leave of Absence is a leave of absence from a secondary educational institution or any change in enrollment at that institution that begins while the student is suffering from a severe illness or injury.

The student's physician must certify that the student has a severe illness or injury and that the leave from school is Medically Necessary. The Company, at its own expense, may require a second examination by a physician specializing in the certified illness or injury. If the second examination does not confirm the certification, the student may be covered after obtaining at his or her own cost another certification from an independent physician specializing in the certified illness or injury.

If following one year of continuation of coverage, the student cannot return to full-time student status under the standard eligibility rules above, coverage under the dental/vision Plan ends. The person losing coverage will be eligible for dental/vision COBRA coverage.

- **Adult Children ages 23 to age 26 are <u>not</u> eligible for the PNA Dental Plan, nor for the PNA Vision Plan.**
- The child, adopted child, or foster child of the employee's dependent child or Adult Child is not eligible for Pilkington-sponsored medical, dental or vision coverage.
- The spouse of a child, adopted child, foster child or Adult Child is not eligible for any Pilkington-sponsored medical, dental or vision plan.
- If the employee's Spouse works full-time for another employer and is eligible for health care coverage through that employer, the employee's spouse must choose at least single coverage through his or her employer to be eligible for dependent coverage under a Pilkington healthcare plan.
- If an employee does not enroll within 30 days of the date first eligible for coverage, such employee and his or her dependents will not be coverable until the next open enrollment period.
- If an employee 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 hospital confined (other than a newborn), coverage will begin the first day following the dependent's discharge from the hospital.

## ELIGIBILITY UPON A COBRA EVENT

Continuation of coverage for active employees 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 employees, spouses or former spouses of employees, 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.

## ELIGIBILITY UPON DISABILITY

For disability (illness or accident) absences commencing on or after January 1, 2000 for represented Ottawa and Lathrop employees, group health care coverage will be continued for employees off work due to sickness or injury for the lesser of:

- the date the employee's disability ends; or
- 30 months; or
- the employee's length of service.

For disability (illness or accident) absences commencing on or after April 1, 2003, an employee who returns to work for a period less than 90 workdays, shall be eligible for a maximum benefit period not to exceed the number of coverage months remaining from the previous period or periods of disability absence.

In the event a disabled employee who is currently eligible for health care coverage is subsequently laid off, group health care coverage will be continued for six months following the month such employee is laid off.

## DUPLICATE COVERAGE

You are not eligible to be covered under more than one Company-sponsored plan at the same time. You are not eligible to be covered under any Company plan as both an employee 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.

## ELIGIBILITY UPON LAY-OFF

Eligible *employees* who are laid off will be covered by group health care coverage for the lesser of:

- Six (6) months following the month in which the employee last worked,
- The end of the month in which seniority terminates, or
- For the number of continuous months of coverage the employee had as an active employee.

An *employee* who is laid off and has been on layoff status and is subsequently recalled, will become eligible for all group health care benefits as follows:

- If the *employee* was on lay-off status for a period less than two years, upon return to work the *employee* will be eligible for all group health care benefits the first of the month following return to work.

- If the *employee* was on lay-off status for a period of two or more years, upon return to work the *employee* will be eligible for all group health care benefits the first of the month following three full months of work.

ELIGIBILITY UPON LEAVE OF ABSENCE OR TERMINATION

In the event a regular full-time employee enters the military service, terminates employment or is on a leave of absence, all coverage will be continued through the end of the month in which the employee last worked.

Employees who are on a Company approved leave of absence under the Family and Medical Leave Act (FMLA) shall be eligible for continued health care coverage for up to the maximum time allowed under FMLA under the same terms and conditions as if they were actively at work.

PRE-EXISTING CONDITIONS

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

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 employee 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 employee requests the coverage within 30 days of the court order. If the court or employee requests coverage after 30 days, coverage will be effective the first day of the month following the date the request was made.

If the employee is not already covered, and a QMSCO requires that a child be covered, the employee will automatically be enrolled as well. If the employee resides in a state which requires the employee to authorize payroll deductions for medical coverage and the employee fails to do so, neither the employee 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).

SPONSORED DEPENDENTS

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

SURVIVORS OF ACTIVE EMPLOYEES

The Company will provide healthcare coverage for eligible surviving spouses and eligible dependents of deceased Ottawa and Lathrop 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.

Surviving spouses of deceased Ottawa and Lathrop employees hired prior to Nov. 1, 1999 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 to any surviving spouse or dependent shall be the same as for a retiree from the respective plant of the deceased employee.
Surviving Spouses and/or eligible dependents of deceased active employees are eligible to choose between:

- continued active employee coverage as specified under the COBRA law, or
- continued coverage under the Hourly Post-employment Healthcare Plan as indicated above.

If the survivor chooses COBRA coverage, the survivor may later enroll during an open enrollment period in the Hourly Post-employment Healthcare Plan.

Coverage for eligible surviving spouses and eligible dependents of deceased Ottawa and Lathrop employees hired on or after November 1, 1999 will continue until the end of the month in which the death of the employee occurs. After that time, benefit continuation will be available in accordance with provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA).

## ENROLLMENT

WHEN YOU MAY ENROLL

### New Employees

If you want to participate in the Health Care Program:

- You are eligible for coverage effective the first day of the month following three months after the date of hire (example: if hired March 15, you are eligible for coverage July 1).
- You must enroll on the internet at **https://pna.employee.com** prior to your eligibility date.
- If you do not enroll prior to your eligibility date:
  - Your welfare benefits for the current enrollment year will only include basic term life insurance (including accidental death and dismemberment) and short-term disability coverage.
  - You will not be enrolled for medical, mental health/chemical dependency, prescription drug, dental, or vision coverage
  - Your next regular opportunity to enroll will be at the next open enrollment (unless in the meantime you have a family status change).

### Open Enrollment

The Company will make every effort to offer every eligible employee the ability to enroll or re-enroll on an annual basis, including employees 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 Employees who enroll prior to their eligibility date will have coverage effective as of the date the employee is first eligible, provided the employee is actively working on that date. Otherwise, coverage will be effective the date the employee returns to work as an active employee.

Existing Employees 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 employee's coverage begins (unless they are added during a subsequent enrollment 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 **https://pna.employee.com** within 30 days of the event, and provide the required documentation.

COST OF COVERAGE

**Employee Medical Contribution and Available Coverage Levels**

You and The Company share the cost of your medical plan. Employees who elect to enroll pay a share of the estimated total cost incurred by The Company through a pre-tax payroll deduction. The amount of the deduction will be announced prior to the open enrollment, and will depend on the program and coverage level chosen by the employee.

Medical coverage levels:
- Employee
- Family

### Employee Dental Contributions and Available Coverage Levels

You and the Company share the cost of your dental plan. Employees who elect to enroll for dental coverage pay a share of the estimated total cost incurred by The Company through a pre-tax payroll deduction. The amount of the deduction will depend on the coverage level chosen by the employee.

Dental coverage levels:
- Employee
- Family

### Employee Vision Contribution and Available Coverage Levels

The Vision plan premium for Ottawa and Lathrop hourly employees who elect to enroll is entirely paid by the Company. The available vision coverage levels are:

- Employee
- Family

### WAIVING COVERAGE

You may choose to not participate in one or more of the health care programs. 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 under Medical, Dental, or Vision, you will not be able to enroll in these programs 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 or work 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 payroll deduction is correct following the reported change. If it is not, please contact the Benefits 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 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 **https://pna.employee.com** or by talking to a Benefits Center Representative at **(800) 685-4335** 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 and their social security card, 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 and their social security card. 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 loses or gains eligibility in his or her employer-sponsored health plan
- Your spouse or dependent has a change in their employment status.

- Your dependent (including an adult dependent) loses or gains coverage elsewhere.

Your benefit change must be consistent with the change in status. For example, if you adopt a child, you may add a dependent in accordance 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 **https://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 spouse/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 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 employee contributions for coverage made on behalf of the ineligible spouse or dependent.

WORK EVENTS

Certain work events may trigger a requirement or opportunity for you to change your benefit elections. Such work events include

- A transfer, or a change in company, location, or address.
- Employment status changes (a termination or commencement of employment)
- A reduction or increase in hours of employment due to a switch between part-time and full-time, or commencement or return from an unpaid leave of absence which had resulted in loss of eligibility under this plan.

Within 30 days after the work event, please check the Pilkington North America website at **https://pna.employee.com** for your new options, if any. These events are automatically reported to the benefits web site vendor through the Company payroll system. If you are eligible to make new benefit elections, there will be an open "work event" shown on the benefits web site after your first payroll under the new company, location, or address. If you have questions about your benefit election options, please call the PNA Benefits Center at (800) 685-4335 or at (419) 247-4714 in the Toledo area.

LEAVES OF ABSENCE

**Eligibility upon Lay-off**

Eligible *employees* who are laid off will be covered by group health care coverage for the lesser of:

- Six (6) months following the month in which the *employee* last worked,
- The end of the month in which seniority terminates, or

- For the number of continuous months of coverage the *employee* had as an active employee.

An *employee* who is laid off and has been on layoff status and is subsequently recalled, will become eligible for all group health care benefits as follows:

- If the *employee* was on lay-off status for a period less than two years, upon return to work the *employee* will be eligible for all group health care benefits the first of the month following return to work.
- If the *employee* was on lay-off status for a period of two or more years, upon return to work the *employee* will be eligible for all group health care benefits the first of the month following three full months of work.

**Sickness and Accident Leave**

For disability (illness or accident) absences commencing on or after January 1, 2000, Ottawa and Lathrop *employee* group health care coverage will be continued for employees off work due to sickness or injury for the lesser of:

- the date the employee's disability ends; or
- 30 months; or
- the employee's length of service; or
- For disability (illness or accident) absences commencing on or after April 1, 2003, an *employee* who returns to work for a period less than 90 workdays, shall be eligible for a maximum benefit period not to exceed the number of coverage months remaining from the previous period or periods of disability absence.

In the event a disabled *employee* who is currently eligible for health care coverage is subsequently laid off, group health care coverage will be continued for six months following the month such *employee* is laid off.

In the event a disabled employee whose Company health coverage has ended returns to work, eligibility for coverage under the Company's health care plan will commence the first of the month following the employee's return to work.

**Family and Medical Leave**

If the Company grants you an approved family or medical leave of absence in accordance with the Family and Medical Leave Act of 1993 (FMLA), you may continue health care coverage for yourself and your eligible dependents during the leave, provided you make your required contributions. This continued participation will not extend beyond the first to occur of the following events:

- The day your FMLA leave ends,
- The day your FMLA leave has reached the maximum 12 weeks per rolling 12-month period, or
- The day you, your Spouse or your dependent's participation would otherwise end.

If coverage ends because your approved FMLA leave ends and you do not return to work, you may be eligible for COBRA continuation benefits. In this case, the COBRA qualifying event is the last day of your FMLA leave.

### Military Leaves of Absence

In the event that an employee who has elected healthcare coverage enters the military service, all employee and dependent coverage is continued through the end of the month in which the employee last worked. Thereafter, activated employees are covered by the military for health care. An employee who would otherwise lose coverage due to entering active military service may choose to continue Company healthcare coverage under the federal law known as COBRA.

Dependents of activated employees can enroll in a federal healthcare program known as TRICARE. However, eligible dependents may elect to continue current employer coverage under COBRA as well.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), COBRA coverage elected by an *employee* or dependent ends upon the first to occur of the following events:

- The day you have been absent from work at the Company for 18 months,
- The day you begin working for another employer after you have been released from military service,
- The day after you have been released from military service but have not returned to work at THE COMPANY within the time limits required by law, or
- The day you or your dependent's participation would otherwise end.

If your coverage is terminated because of military service and you later return to PNA after your release from military service within the time limits required by law, no eligibility waiting periods will apply. However, any applicable exclusions will apply to coverage for any injury or illness the Secretary of Veteran Affairs determines to have occurred or to have been aggravated during your military service.

TERMINATION
In the event an employee's employment is terminated, all coverage will be continued through the end of the month in which the employee last worked.

## 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 dependent.

- Except in the case of a legally separated or divorced employee, 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

Medicare is a benefit plan administered by the federal government which in general provides eligibility for government paid medical benefits:

- For persons who have reached age 65, if you have paid into Social Security for at least 10 years or you are eligible to receive Social Security benefits on your spouse's earnings, or
- After a person has received Social Security disability benefits for a period of 24 months, or
- If a person suffers from end-stage renal disease.

*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. Center for Medicare & Medicaid Services and then review your personal eligibility for Medicare, as well as specific Medicare benefit details.*

WHAT MEDICARE COVERS

This government sponsored plan has three parts:

- **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 PNA Plan with respect to Medicare

In general, coverage for active employees and dependents through the Company is primary and Medicare coverage is secondary. (Medicare considers itself a secondary payer of medical claim coverage provided to a working employee or the spouse of a working employee when the employer's plan provides coverage to the spouse.)

You should contact Medicare to enroll in Part A as soon as you are eligible. 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.

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 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, the Medical Plan will continue to provide primary medical coverage. The spouse or dependent should also consider enrolling in Medicare Part B in order to provide secondary protection.

**End-Stage Renal Disease**

If you, your spouse or dependent have end-stage renal disease and qualify for Medicare benefits, the 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). After that, Medicare will provide 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.

### Medicare Co-ordination during Retirement

If you are eligible for post-employment healthcare coverage through *The Company* when you retire, when you become eligible for Medicare, Medicare will be the primary plan and the *Company's Plan* will be secondary.

## REIMBURSEMENT, SUBROGATION, RIGHT OF RECOVERY

If you, your eligible spouse or eligible dependent (a Plan participant) incurs a covered expense for which, in the opinion of the Plan or it's claim administrator, another party may be responsible or for which the Plan participant may receive payment either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage:

**Subrogation:** The Plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Plan participant may have against such party and shall automatically have a lien upon the proceeds of any recovery by a Plan participant from such party to the extent of any benefits paid under the Plan. A Plan participant or his/her representative shall execute such documents as may be required to secure the Plan's subrogation rights.

**Right of Reimbursement:** The Plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted above, but only to the extent of the benefits provided by the plan.

By accepting benefits under this Plan the Plan participant grants a lien and assigns to the Plan an amount equal to the benefits paid under the Plan against any recovery made by or on behalf of the Plan participant which is binding on any attorney or other party who represents the Plan participant whether or not an agent of the Plan participant or of any insurance company or other financially responsible party against whom a Plan participant may have a claim provided said attorney, insurance carrier or other party has been notified by the Plan or its agents. This lien shall constitute a charge against the proceeds of any recovery and the Plan shall be entitled to assert a security interest thereon. The Plan participant agrees to hold the proceeds of any recovery in trust for the benefit of the Plan to the extent of any payment made by the Plan.

### Additional terms:

No adult Plan participant may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor dependent of said adult without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.

No Plan participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.

The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Plan participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.

No plan participant hereunder shall incur any expenses on behalf of the plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorney's fees or other representative's fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Plan participant, whether under comparative negligence or otherwise.

In the event that a Plan participant shall fail or refuse to honor its obligation hereunder, then the Plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The Plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Plan participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.

By acceptance of benefits under the Plan, the Plan participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the Plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

## 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 that your employment with the Company ends
- The last day of the month that your eligibility for coverage ends
- The day you die
- 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 end of a period during which you are eligible to participate in the *Plan* while not actively at work
- The last day of the month in which you last worked before you enter full-time military service exceeding 30 days

- The date the Plan is terminated

Spouse and dependent coverage 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".

### POST-EMPLOYMENT COVERAGE

An employee **hired on or before December 31, 1988** 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 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.

## 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 NETWORK

The Comprehensive PPO Medical Plan is a plan offered at every Company location. When obtaining services covered under the Comprehensive preferred provider program, plan participants may choose a provider each time they obtain services, and do not have to designate a Primary Care Physician.

Under a preferred provider 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 that belongs to the network or a provider that does not belong to the network whenever you or a dependent needs medical care. The choice is yours:

- 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.

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 1-800-244-6224. 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 program includes a utilization review program to manage your costs and the plan's costs by reviewing whether proposed treatment plans are medically necessary and certify length of a hospital confinement. This program includes:

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

Only in-network health care professionals are responsible to obtain authorization on your behalf. For out-of-network services you are responsible to obtain all necessary authorizations. 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 in-network doctor must call CIGNA at (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*, you or your in-network doctor must contact CIGNA within 48 hours after the admission.

For an admission due to pregnancy, you or your in-network doctor should call CIGNA by the end of the third month of pregnancy.

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 employee 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 employees 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 to age 18. For information on the allowed number and type of well-child services, call CIGNA at (800) 244-6224.

Certain immunizations are covered. 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.

*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,
- 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,
- Curative or life-prolonging procedures.

*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 services are subject to a co-payment. The co-payment is waived if admission to the hospital occurs. The Emergency Room benefit is administered on the basis of the symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the claim form or final diagnosis, whichever reasonably indicated an emergency medical condition provided such symptoms reasonably indicate an emergency.

### *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 *employee* 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* in nature.
- 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.

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.

Multiple Surgical Reduction: Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon Charges: The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge.

(For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reduction due to coinsurance or deductible amounts).

Co-Surgeon Charges: The maximum amount payable will be limited to 62.5 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reduction due to coinsurance or deductible amounts).

*Obstetrical and Gynecological Services*

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

You do not need prior authorization from the Pilkington North America Plan nor from any Plan Administrator or insurer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our networks who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Claim Administrator or issuer at the address or phone shown later in this Summary Plan Description under "Healthcare Plan Contacts".

MENTAL HEALTH AND CHEMICAL DEPENDENCY PROGRAM

If you enroll in the Comprehensive Medical Plan option, you and any eligible dependents (if you cover them) are automatically covered by the Mental Health and Chemical Dependency program.

The Mental Health and Chemical Dependency program provides benefits through CIGNA which are paid at the same level as medical benefits. CIGNA has a network of medical and mental health care providers that have contracted to provide services for negotiated, reduced rates. If you need care, you may choose to receive it from a provider who belongs to the CIGNA network or a provider that does *not* belong to the network. The choice is yours, but:

- **Important note:** all services under the Mental Health and Chemical Dependency Plan must be pre-certified through CIGNA or there will be no coverage for services rendered.
- 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, if they were pre-certified by CIGNA. If the non-network claim was pre-certified, it will be paid on a *Reasonable & Customary* basis.

### What the Mental Health and Chemical Dependency Program Covers

The Mental Health & Chemical Dependency Program covers effective treatment on both an outpatient and an inpatient basis.

- Inpatient Treatment: Depending on your needs, CIGNA may authorize that your services be provided in a hospital, residential treatment center, partial hospitalization, group home, or halfway house setting.

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

Federal mental health legislation requires parity between medical/surgical benefits and mental health or substance use disorder (MH/SUD) benefits with respect to annual dollar limits, financial requirements (such as co-pays and deductibles) and treatment limitations (such as visit limits). PNA plans will:

- Offer the same access to care and patient costs for mental health and substance use disorder benefits as those that apply to general medical or surgical benefits.
- Treat them equally in terms of out-of-pocket costs, benefit limits and practices such as prior authorization and utilization review used by the insurer for medical and surgical benefits.
- Where applicable, contain a single combined deductible for mental health and medical/surgical coverage.

**Mental Health & Chemical Dependency Program Exclusions and Limitations**

The following is a list of those services that are excluded from coverage under the managed Mental Health & Chemical Dependency program:

- Ancillary Mental Health & Chemical Dependency services such as vocational rehabilitation, behavioral training, sleep therapy, employment counseling, training or education therapy for learning disabilities or other education services;
- Mental Health & Chemical Dependency Services, treatment or supplies provided by a Network Provider without prior authorization except those provided as Emergency Treatment
- Behavior modification or other treatment of obesity or weight reduction, or for the cessation of smoking, including surgery and supplies;
- 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;
- 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 & Chemical Dependency Services, treatment and supplies primarily for rest, custodial, domiciliary or convalescent care;
- Treatment of pervasive developmental disorders, including, but not limited to, autism, learning disabilities, behavioral disabilities, developmental reading disorder, developmental arithmetic disorder of developmental articulation disorder;
- All Mental Health & Chemical Dependency prescription or non-prescription drugs, except for drugs prescribed by a Network Provider in the course of a Member's treatment as an inpatient;

- 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);
- Mental Health And Chemical Dependency Services, treatment or supplies determined to be *Experimental Services*;
- Inpatient Mental Health And Chemical Dependency services, treatment or supplies provided without prior authorization except those provided as Emergency Treatment;
- Conditions the primary diagnoses of which are medical;
- Marriage counseling, except for the treatment of a Mental Health/Substance Abuse Condition
- Mental Health And Chemical Dependency Services, treatment or supplies rendered to a Member which are *not medically necessary;*
- Treatment of mental retardation, other than the initial diagnosis;
- 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;
- Treatment of pain, except for Medically Necessary treatment of pain with psychological or psychosomatic origins;
- Diagnosis and treatment for personal growth and/or development or in conjunction with professional certification;
- Mental health and chemical dependency private hospital rooms and/or private duty nursing, unless determined to be medically necessary and authorized by CIGNA;
- Other psychological testing, except when conducted for the purpose of diagnosis of a Mental Health/Substance Abuse Condition;
- Sex therapy, treatment for sexual deviance or diagnosis or treatment in conjunction with sexual reassignment procedures;
- Stress management therapy;
- 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;
- MENTAL HEALTH AND CHEMICAL DEPENDENCY 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 Member provides CIGNA with a lien against such claim for damages or relief in a form and manner satisfactory to CIGNA; or
- Any service or benefit not covered under the medical portion of the group health plan.

How to Submit a Mental Health or Chemical Dependency Claim
If you use a **CIGNA network provider**, pay the appropriate coinsurance, and the provider will submit a claim for payment from CIGNA.

If you use a **non-network provider**, pay the provider the full amount and submit a claim for reimbursement to CIGNA.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

You are eligible to receive Employee Assistance Program (EAP) benefits, regardless of whether you choose coverage under a Pilkington North America Medical Plan. The Employee Assistance Program (EAP) provides confidential, professional counseling for emotional problems related to:

- Alcoholism
- Drug dependence
- Marital or family problems
- Job-related stress
- Financial problems
- Legal problems

The EAP provides assessment, initial counseling, and referral services at no cost to you. You will, however, be responsible for any additional help you may receive beyond EAP services, such as marital, financial, or legal counseling. For EAP counseling, call CIGNA Behavioral at **(888) 371-1125**. Counselors are available to assist you 24 hours a day, 7 days a week.

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 **Express Scripts, Inc (ESI)**, which is the administrator of the retail pharmacy network and claims and of the mail order service claims.

ESI has a national network of **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 network or a pharmacy that does not belong to the network. The choice is yours to make. However, if you use a network pharmacy, your benefits will generally be paid at a higher level.

### Highlights of the Prescription Drug Program

These highlights show the Plan's coverage for covered prescription drugs. The Company's share of the cost is 80%, with the employee or patient share set at 20%.

For more complete information about what the Plan covers, you should see the "What the Plan Covers" and the "What Is Not Covered" sections in this booklet.

| Prescription Drug Program | Retail Pharmacy | Mail Order Service |
|---|---|---|
| *Covered drugs* | Rx Selections Formulary (Maintenance and non-maintenance drugs) | Rx Selections Formulary (Maintenance drugs) |
| *Maximum supply* | 30 days | 90 days |
| *Fill limit* | 3 (Prescription + 2 refills) | None |
| *Deductible* | None | None |
| *Coinsurance* | 20 % | 20 % |
| *Co-insurance Minimum ** | See Benefits Highlights chart | See Benefits Highlights chart |
| *Co-insurance Maximum ** | See Benefits Highlights chart | See Benefits Highlights chart |

* Per prescription or refill.

**What Drugs Are Covered**

The prescription drug plan covers drugs on the ESI formulary. A "formulary" is a list of covered drugs. The list is assembled by an independent committee of pharmacists and physicians. The ESI formulary list which applies to eligible participants in this health Plan is the **Rx Selections Formulary**.

To find out if a medication your doctor is prescribing is covered by the Plan, you or your doctor may call Member Services at **(800) 417-1916**, or you may go on-line at **www.express-scripts.com .**

The Prescription Drug formulary covers medically necessary drugs 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 (e.g. syringes, needles, lancets and test strips) when purchased with insulin

The following prescription drugs are covered only with a prior authorization (p.a.) by ESI, including diagnosis certification. For a complete list, check with ESI Member Services.

- Avonex
- CNS stimulants (amphetamines)
- Cognex/Aricept
- Copaxone
- Crinone
- Erythroid stimulants (Procit and Epogen)
- Extavi
- Myeloid stimulants (Neupogen and Leukine)
- Growth hormones
- Immunomodulators (Interferon)
- Rebif
- Retin-A if used to treat pre-cancerous conditions or acne vulgaris
- Pulmozyme

- Testosterone

The following prescription drugs may be covered, depending on the circumstances noted.

- Angiotensin Receptor Agonists (ESI reviews previous medication history, if none, prior authorization (p.a.) is needed)
- Cox II's (over age 65 or previous medication history, if neither, p.a. 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)

**Network Retail Pharmacy Service**

To fill or refill a prescription at a participating network pharmacy, you simply present your pharmacy identification card and pay the appropriate co-insurance for each medication you receive. **Pharmacies** in the **network** will submit all claims for payment.

You can normally get up to a 30 day supply plus two (2) refills, or 3 total fills, for each prescription at a retail pharmacy. You will pay your participating retail pharmacy co-payment at the point of service. After that, you must choose the mail order service for long term/maintenance drugs or beginning with the fourth fill you will pay the **entire** cost of the drug. These provisions may not apply if:

- The prescription is filled and dispensed by a nursing home in which the patient is confined
- The prescription is for a Level II controlled substance
- The drug manufacturer recommends that the medication be dispensed in a supply of 30 days or less (e.g. 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 network, you must pay the provider in full for the prescription, obtain an itemized receipt, and submit a claim for reimbursement yourself to ESI. ESI will only 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. To submit a claim, you must call Member Services at **(800) 417-1916** and request a claim form.

**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 mail order pharmacy (Express Scripts Pharmacy). The Express Scripts Pharmacy provides full-service prescription fulfillment, including delivery of your order to you through the mail. Your benefit includes mail order to offer you convenience and cost savings on prescription drugs that you take on a long-term basis. Express Scripts follows strict quality and safety controls for every prescription filled, and the pharmacies are staffed with registered pharmacists. You may get up to a 90-day supply of your prescribed medication for each fill.

To get started:

Call **1 800 417-1916** to speak with a Member Services representative. With your approval, ESI will contact your doctor to make arrangements for your first 90-day prescription via mail order.

For refills remaining on long-term prescriptions that you've been filling at retail, log in to **www.express-scripts.com**. Scroll down the "Order Center" page to "Transfer your retail prescriptions to mail service." Select the medications you'd like to transfer to the **Express Scripts Pharmacy.** ESI will do the rest.

Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year, if appropriate. Next, for fastest service, ask your doctor to send that prescription directly to the Express Scripts Home Delivery Pharmacy by e-prescribing. Or you can mail the new prescription with the pre-printed order form and self-addressed envelope.

Once your order is received, please allow 10 to 14 days for your order to be delivered to your home. If the prescription order has insufficient information, or if we need to contact you or your prescribing doctor, delivery could take longer.

Express Scripts therefore recommends first time users of the **Express Scripts Home Delivery Pharmacy** to ask your doctor for two signed prescriptions:

- One for an initial supply to be filled at your local pharmacy.
- The second for up to a 3-month supply with refills to send to Express Scripts.

When Express Scripts contacts your doctor on your behalf to obtain a new prescription for home delivery, the process typically takes 2 to 3 weeks. If your doctor cannot be reached, you will be notified via phone, if a valid phone number is on file. Otherwise, a letter will be mailed to you.

To order your medication through the Express Scripts Home Delivery Pharmacy:

- Make sure your physician knows you are covered by a home delivery order prescription drug service.
- Ask your physician to write your prescription to allow up to a 90 day supply, plus 3 refills.
- Submit the prescription to the Express Scripts Home Delivery Pharmacy using the tools described in "to get started" referenced above.
- You may pay for your home delivery orders by check or money order made payable to "Express Scripts, Inc.". You may also authorize ESI to bill your credit card directly (MasterCARD®, VISA® or DISCOVER® are accepted).
- 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 Member Services at 1-800-417-1916. 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, ESI will credit your account.

- If you send a check or money order and there is a balance of $100 or less due, ESI 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 refill prescriptions until all past balances are collected. Once you are paid in full, the standard co-insurance will apply to new or refill 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, ESI will attempt to contact you to give you your options before shipment.

### 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
- Anti-neoplastic 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 muscle relaxants
- Irrigation solutions
- Male contraceptive devices
- 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
- Non-sedating antihistamines
- 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
- Certain Toxoids, serums and vaccines

OTHER MEDICAL EXPENSES

The *Plan* 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
- Behavioral Expenses (through the CIGNA program; see Mental Health section)
- Cataract Surgery: Eyeglasses Or Contact Lenses Following Cataract Surgery
- Chemical Dependency, including alcoholism treatment (through CIGNA program)
- Chemotherapy
- Chiropractic services, including X-rays, diagnostic lab tests, adjustments, traction, massage therapy and kinesiotherapy. These services are subject to an annual maximum per person (see the Benefits Highlights chart) provided the services are medically necessary and subject to the claims administrator's guidelines.
- Dental charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of an accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- 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: Maximum of $3,100 per three calendar year including exam, testing and fitting of appliances. Routine exams are not covered. (If a network provider is not used, the charges are subject to Reasonable & Customary provisions.)

- Hemodialysis – use of artificial kidney machine
- Home Health Care

  Home Health Care is hospital or skilled nursing care services that can be provided during intermittent visits of two hours or less 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 services, the patient's physician must refer him or her, the care must be provided by a home health care professional (services provided by a Home Health Care Aide are excluded), and the home health care must be pre-certified as medically necessary and appropriate by the utilization review administrator.

  Necessary consumable medical supplies, home infusion therapy and Durable Medical Equipment administered or used by the home health care professionals in providing home health care services are covered.

  Home health care services do not include services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house.

  Physical, occupational and restorative speech therapy provided in the home are subject to the outpatient rehabilitative services of the Plan.
- Hyperbaric chamber oxygenation
- Infertility treatment, including infertility drugs
- Laboratory and X-ray tests, services, and materials
- Life Threatening Emergencies
  - Medical treatment required as a result of a life-threatening emergency, such as a suicide attempt, will be considered a medical expense until the medical condition is stabilized and will not count toward any plan limits that are shown in the Schedule for mental health and substance abuse services including in-hospital services.
  - Once the medical condition is stabilized, whether the treatment will be characterized as either a medical expense or a mental health/substance abuse expense will be determined in accordance with the applicable mixed services guidelines.
- Massage therapy (see chiropractic services),
- Maternity care including routine prenatal and postnatal care,
- Newborn care when the eligible newborn is added to the employee's coverage as a dependent within 30 days,
- 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 transplants - Charges for human organ and tissue transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the US or its territories.

Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered 100% when received at CIGNA LIFESOURCE Transplant Network facilities. Transplant services, including cornea, received outside the LIFESOURCE Transplant Network facilities are payable at the In-Network or Out-of-Network levels shown in the Benefits Highlights chart.

Transplant travel services (subject to pre-approved limitations) may also be available to the recipient of the organ transplant and one qualified companion.

- Orthognathic Surgery

  Orthognathic surgery to repair or correct a severe facial deformity or disfigurement which orthodontics alone cannot correct is covered provided that:
  - The deformity or disfigurement is accompanied by a documented, clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement, or
  - The orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease, or
  - The orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when:
  - The previous orthognathic surgery met the above requirements, and
  - There is a high probability of significant additional improvement as determined by the Third Party Administrator.
- Physical therapy

  Charges are covered if prescribed by a physician, performed by a licensed physical therapist, and result in significant improvement of bodily function.
- Private duty nursing, whether provided in a hospital or a home (subject to limitation stated in Benefits Highlights)
- Prostheses

  Coverage for external prosthetic appliances and devices is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.
- Radiological services, such as X-ray services and MRI
- Rehabilitative Services on an outpatient basis, including testing, physical therapy, occupational therapy, and speech therapy

  Phase I Cardiac Rehabilitation services are covered separately from the Outpatient Short Term rehabilitation benefit, subject to the following:

- Requires medical necessity (as determined by the Third Party Administrator),
- Requires case management, and
- Limited to a maximum of 36 days per year. (The maximum may vary based on individual member needs, not to exceed 36 days).

Phase II cardiac rehabilitation may be provided on an outpatient basis following diagnosis of a qualifying cardiac condition when medically necessary. Phase II is a Hospital-based outpatient program which follows an inpatient Hospital discharge. The Phase II program must be physician directed with active treatment and EKG monitoring.

Phase III and Phase IV cardiac rehabilitation services are not covered. (Phase III follows Phase II and is generally conducted at a recreational facility primarily to maintain the patient's status achieved through Phase I and II. Phase IV is an advancement of Phase III which includes more active participation and weight training.)

- Sterilization for the employee 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 covered under the optional vision plan. Surgery or other procedures to correct vision are not covered.

## EMPLOYEE MEDICAL CONTRIBUTIONS

Participating employees will contribute on a pre-tax basis to the cost of the Medical Plan or Alternate Plan (if available) elected during their enrollment through payroll deduction or direct billing (when the payroll check is not adequate to cover the contribution). Employee medical contributions will be based on the schedule shown in the Benefits Highlights chart shown earlier in this Summary Plan Description.

## POST-EMPLOYMENT CONTRIBUTIONS

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) shall be required to pay 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.

Effective April 1, 2003, all retirees who elect to participate in the post-employment healthcare plan pay a monthly contribution. More information is available in the Post

Employment Health Care Agreement between Pilkington North America and the United Steelworkers of America, AFL-CIO, CLC. That agreement was effective April 1, 2003.

## DENTAL PLAN

The Dental Plan covers eligible expenses for the care of your teeth and gums. To be covered, charges must be:

- For services and supplies which are necessary (as indicated by the American Dental Association),
- Performed or billed by a licensed dentist, and
- Within *Reasonable and Customary* limits.

DENTAL PLAN HIGHLIGHTS

| | |
|---|---|
| **Deductible** | None |
| **Coinsurance:** | |
| Preventive Care | Plan pays 100%, you pay 0% |
| Minor Restorative Services | Plan pays 75%, you pay 25% |
| Major Restorative Services | Plan pays 50%, you pay 50% |
| **Maximum Annual Benefit** | $1,200 per person |
| **Maximum Lifetime Orthodontic Benefit*** | $1,500 per person |

- Orthodontic services are covered only for dependent children participating in the plan, and only when treatment begins before age 19.

WHAT THE DENTAL PLAN COVERS

### Preventive Dental Services

The Plan covers the following preventive services at 100%:

- Two routine oral exams per year, including initial and periodic exams
- Two cleanings per year
- One topical fluoride treatment per year for persons under age 19
- Space maintainers for dependent children under age 19
- Emergency treatment to temporarily relieve acute pain
- Two fissure sealants per tooth per lifetime for dependent children under age 19

### Basic Dental Services

The Plan covers the following basic services at 75%:

- Administration of general anesthesia or intravenous sedation,
- Injections of antibiotic drugs
- Biopsies
  - A Biopsy of oral tissue, including brush biopsy, is covered when medically necessary.
  - Coverage includes an allowance for local anesthesia and routine postoperative care.
- Two sets of bitewing X-rays (and other dental X-rays as required to diagnose a specific condition requiring treatment) per year

- Endodontic treatment (prevention and treatment of diseases of the dental pulp), including root canal therapy, and
- Extractions
- Fillings,
- Oral Health Integration Programs
  If you are a CIGNA Dental plan member as well as a member of a CIGNA medical plan, you may also be eligible for additional dental benefits during certain episodes of care. For example, some frequency limitations for dental services may be changed for pregnant women, diabetics or those with cardiac disease. For more information, contact the Third Party Administrator about the following Oral Health Integration Programs:
  - Oral Health Maternity Program (OHMP)
  - Oral Health Cardiovascular Program (OHCP)
  - Oral Health Diabetes Program (OHDP)
- Oral surgery
- Periodontal treatment (treatment of diseases of the gums), such as scaling,
- One full-mouth X-ray every 36 months

**Major Dental Services**

The Plan covers the following major services at 50%:

- Initial installation of fixed bridgework,
- Initial installation of partial or full removable dentures, including adjustments during the six-month period following the installation,
- Inlays, on-lays, gold fillings, or crown restorations,
- Repair or re-cementing of crowns, inlays, on-lays, bridgework, or dentures (re-lining or re-basing of dentures more than six months after installation limited to once in a 36-month period),
- Replacement of existing dentures or bridgework (limited to once every five years).

**Orthodontic Services**

The Plan covers the following orthodontic services for dependent children at 50% (when treatment begins before age 19): orthodontic procedures and treatment, including related oral exams, surgery, and extractions, appliance therapy; and functional/myofunctional therapy.

ADVANCE DENTAL CLAIM REVIEW (*PRE-DETERMINATION*)

If you are about to have dental care that is expected to cost more than $200, you may want to have your dentist submit a predetermination of benefits (using a dental claim form) to the Dental Plan claims administrator:

**CIGNA Dental Claims**
**P.O. Box 188037**
**Chattanooga, TN 37422-8037**

Member Services: (800) 244-6224

The claims administrator will review the proposed treatment and associated costs and send both you and your dentist an Explanation of Benefits showing what the Plan would cover.

Please note: Predetermination of benefits is completely optional, but strongly recommended for dental claims expected to exceed $200. It is a good way to find out exactly how much the Plan will pay (and how much you will owe) before you actually order dental work.

## WHAT THE DENTAL PLAN DOES NOT COVER

The Dental Plan does not cover certain expenses, including the following:

- Dental services and oral surgery in connection with an illness or injury (may be covered by the Medical Plan),
- Treatment of temporomandibular joints (TMJ) (surgical or nonsurgical),
- Treatment provided by someone who is not a dentist (except for scaling or cleaning of teeth and topical application of fluoride performed by a licensed dental hygienist under the supervision of a dentist and billed by a dentist),
- Veneers or similar properties of crowns and pontics placed on or replacing teeth other than the 10 upper and 10 lower anterior teeth,
- Minor occlusal adjustments, except those performed within three months of osseous surgery
- Services or supplies that are cosmetic or personal in nature, including charges for the personalization or characterization of dentures
- Replacement of lost, missing, or stolen prosthetic devices
- Replacement or repair of orthodontic appliances
- Duplicate or "spare" appliances
- Instruction on oral hygiene and diet
- Plaque control programs
- Use of nitrous oxide
- Implants
- Periodontal splinting

## HOW TO SUBMIT A DENTAL CLAIM

Some dental providers will file a claim for payment for you after you pay the appropriate coinsurance. If your dental provider will not file your claim, you should pay the provider in full and submit a claim for reimbursement to the Dental Plan Claims Administrator.

To submit a claim, have your dental provider complete an Attending Dentist's Statement Claim Form. Send the claim to one of these addresses (depending on the date the claim was incurred):

**CIGNA Dental Claims**
**P.O. Box 188037**
**Chattanooga, TN 37422-8037**

Member Services: (800) 244-6224

EMPLOYEE DENTAL CONTRIBUTIONS

Employees will contribute on a pre-tax basis to the cost of the Dental Plan elected during their enrollment through payroll deduction or direct billing (when the payroll check is not adequate to cover the contribution) based on the following contribution schedule.

| Effective Payroll Date | **Employee Only** | **Family** |
|---|---|---|
| January 2, 2012 | 14% | 14% |
| January 7, 2013 | 14% | 14% |
| January 6, 2014 | 14% | 14% |

## VISION PLAN

The Company provides optional vision coverage for Ottawa and Lathrop employees and their eligible dependents. The entire Vision Plan premium is paid by the Company.

The Vision Plan provides benefits through **United Healthcare Vision**. United Healthcare Vision contracts with a network of vision care providers to provide services at negotiated, reduced rates. Whenever you need vision care, you may choose whether to see a provider who belongs to the United Healthcare Vision network or a provider who does *not* belong to the network. The choice is yours. However, if you use a network provider, your benefits will be paid at a higher level.

## VISION PLAN HIGHLIGHTS - UNITED HEALTHCARE VISION

| **Service** | **In-Network** | **Non-Network** |
|---|---|---|
| **Exam**<br>Once every 12 months | Plan pays 100%. | Plan reimburses up to $40 |
| **Eyeglass Lenses**<br>One pair every 12 months | Plan pays 100%. * | Plan reimburses up to:<br>$40 for single vision<br>$60 for bifocal lenses<br>$80 for trifocal lenses<br>$80 for lenticular lenses |
| **Eyeglass Frames**<br>Once every 24 months | Plan pays 100% up to a maximum of $130. | Plan reimburses up to $45 |
| **Contact Lenses**<br>Four boxes once every 12 months in place of glasses/frames | Plan pays 100% on *covered* contact lenses (including evaluation and fitting charges). For contact lenses not included in the covered selection, a $105 allowance will be applied and you will pay the balance. | Plan reimburses up to $105 |

| | | |
|---|---|---|
| **Medically NecessaryContact Lenses**<br>Once every 12 months in place of glasses | Plan pays 100% | Plan reimburses up to $210 |

** Lenses: Standard scratch-resistant coating is covered in full. Lens options such as progressive lenses, polycarbonate lenses, tints, UV and anti-reflective coatings may be available at a discount. Frames: if you select a frame outside of covered-in-full selection, you will receive a $50 wholesale frame allowance at private practice providers, or a minimum $120 retail frame allowance at United Healthcare Vision's retail chain providers.*

### How the United Healthcare Vision Program Works

To find a **United Healthcare Vision network provider**:

1. Call **1-800-839-3242** or visit the United Healthcare Vision website at www.myuhcvision.com to find out if a particular provider belongs to the network or to get a referral for network providers in your area.
2. Call a network provider, identify yourself as a United Healthcare Vision member, and make an appointment. The provider will contact United Healthcare Vision to verify eligibility and get authorization for services and materials. The provider will explain to you any additional charges you may have.
3. Receive your services and pay any applicable co-payments. The network provider will file a claim for payment with United Healthcare Vision.

If you choose to see a **non-network provider**, pay the provider in full and submit a claim for reimbursement to United Healthcare Vision.

### What the United Healthcare Vision Program Covers

The Vision Plan covers the following expenses at the levels shown previously.

- Vision exams – complete analysis of the eyes and related structures to determine the presence of vision problems.
- Eyeglasses – single vision lenses, bifocal lenses, trifocal lenses, lenticular lenses, and frames. Additional charges for elective materials and services are not covered, but the following options are available at reduced prices from network providers:
    - Blended or progressive lenses
    - Oversize lenses
    - Special edging
    - Tints
    - Special lens materials

- Coatings
- "Designer" frames
- Elective contact lenses – prescription contact lenses for a person who could wear eyeglasses

- Medically Necessary Contact Lenses are available where a provider has determined a need for and has prescribed the service. Contact lenses are necessary if the Covered Person has:
  - To correct extreme visual acuity not correctable with eyeglasses
  - Keratoconus
  - Anisometropia
  - Irregular corneal/astigmatism
  - Aphakia
  - Facial deformity; or
  - Corneal deformity

**What Is Not Covered in the United Healthcare Vision Program**

Expenses that are not covered include, but are not limited to:

- Charges outside the allowance for a particular benefit including optional lens extras
- Replacement or repair of lenses and/or frames that have been lost or broken
- Orthoptics
- Vision training
- Non-prescription items
- Medical and/or surgical treatment of the eyes
- Eye exams required as a condition of employment
- Post-cataract claims
- Worker's compensation or other similar liability law services or materials
- Services or materials that the patient, without cost, obtains from a governmental organization or program
- Missed appointment charges or applicable sales tax charged
- Services, treatment, device or pharmacological regimens that are considered to be Experimental, Investigational or Unproven in the treatment of that particular condition

**How to Submit a United Healthcare Vision Claim**

If you chose to see a network provider, pay the appropriate co-payment, and the provider will file a claim for payment with United Healthcare Vision.

If you see a non-network provider, pay the provider in full and submit a claim for reimbursement. To submit a claim:

1. Get am itemized receipt from your provider in full and submit the following information:
   - Patient's name and date of birth,
   - Date services were rendered
   - Services and materials received

- Type of lenses the patient received (e.g., single, bifocal, trifocal, etc.)
- The employee's name and Vision ID number or Social Security number

2. Mail the receipt and the above information to :

**United Healthcare Vision Claims Department**
**P.O. Box 30978**
**Salt Lake City, Utah 84130**

3. Or fax the receipt and above information to: (248) 733-6060

**Important United Healthcare Vision claims note:** Receipts for materials and/or services received on different dates must be submitted together in order to receive the maximum allowance reimbursement under the plan. For example, if you go to one optometrist for your eye exam and to another provider to purchase your contact lenses, you must submit both itemized receipts to United Healthcare Vision at the same time. Further, if you purchase disposable contact lenses and do not purchase your one year supply at the same time, you need to save your receipts and submit all at one time to United Healthcare Vision.

The United Healthcare Vision Customer Service Center may be reached at **(800) 839-3242**.

## 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
- 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 treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition.
- Dental implants for any condition
- 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
- Treatment of pervasive developmental disorders, including, but not limited to, autism, learning disabilities, behavioral disabilities, developmental 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 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
- Legal services.
- Charges for services you are not legally required to pay
- Massage Therapy unless covered under chiropractic services.
- 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)
- 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

- Treatment of temporomandibular joints (TMJ) (surgical or nonsurgical)
- 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
- Wigs and hairpieces
- 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
- 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. HEALTH CARE PRE-TAX REIMBURSEMENT ACCOUNT

The Health Care Pre-tax Reimbursement Plan, under Section 125 of the Internal Revenue Code, allows you to set aside a predetermined amount of money on an annual basis to pay for certain expenses which are not covered under your Medical, Dental or Vision Plans. The net effect is that the employee saves on taxes. Such plans are called pre-tax reimbursement accounts or flexible spending accounts.

### GENERAL OPERATION AND LIMITATIONS

ELIGIBILITY

Participation is optional. All employees participating in a COMPANY-sponsored Medical or Dental Plan, PPO, or an HMO are eligible to participate in this Pre-tax Reimbursement Account. Eligible employees who have waived health care coverage may also participate. Retirees are not eligible, nor are dependents as individuals, although expenses incurred by you on behalf of your dependents (those who qualify under IRS rules) will be reimbursable.

PLAN YEAR

The Plan operates on a calendar year basis (the "Plan Year"). The "Extended Plan Year" closes on the April 30 immediately following the Plan Year. Expenses incurred during the Plan Year may be submitted for reimbursement from January 1 of the plan year through April 30 of the year following the Plan Year.

If you elect to participate, you must decide prior to the beginning of the Plan year. New hires and those returning from leave or lay-off must enroll within 31 days of initial eligibility or reinstatement and prior to incurring expenses for reimbursement account purposes

HOW THE PLAN WORKS

Prior to the beginning of the Plan Year you may designate a specific amount to be withheld from your gross pay to be used by you for medical expenses incurred during the year. (Claims applied against your account may be incurred beginning January 1 of the Plan Year and through March 15 of the following calendar year.) You do not pay federal income tax or Social Security tax on this amount. It is deducted from your gross pay before taxes.

Whatever amount you specify on the annual enrollment web site will be withheld and credited to your account on a regular, standard basis through payroll deduction. The withholding period (weekly, biweekly, semi-monthly or monthly) is determined by the payroll cycle for your particular location. The minimum amount you can elect is $120 per year. You are limited to a maximum pre-tax contribution of $2,500 per Plan year.

Contribution levels cannot be changed during the Plan year unless there is a major modification in your family's status: marriage, divorce, death of a Spouse or dependent, birth or adoption of a child, or your Spouse's gain or loss of employment. You have 60 days from the date of the major modification to change your contribution level.

ELIGIBLE PERSONAL HEALTHCARE EXPENSES

If you participate in the Health Care Pre-Tax Reimbursement Account, you may submit healthcare expenses for you and all your eligible dependents, regardless of whether you cover them under the Medical, Dental, and Vision plans.

ALLOWABLE EXPENSES

Certain expenses which are not covered by the Health Care Plan are eligible for coverage under the Health Care Reimbursement Account. They include:

- Deductibles.
- Co-payments.
- Excess charges over *Reasonable and Customary* fees.
- Other non-covered medical, dental, vision or hearing expenses providing they are classified as "deductible" under the IRS Code (not actually deducted).

REIMBURSEMENT OF EXPENSES

Claims submitted against your account may be incurred beginning January 1 of the Plan Year and through March 15 of the following calendar year. You may submit a claim for reimbursement throughout the Plan year until April 30 of the following year to settle allowable health care related expenses incurred during the Plan Year as noted above.

Other qualifying expenses may be submitted directly by you to CONEXIS for reimbursement. The Special Reimbursement Request form should be used to submit these expenses, and they must be accompanied by evidence of the expense, such as a bill or receipt.

Requests for reimbursement of allowable items from the Account will be paid up to the annual amount you have elected to contribute for the entire Plan year. All reimbursements will be accompanied by an Explanation of Payment.

HOW TO FILE PRE-TAX REIMBURSEMENT ACCOUNT CLAIMS

Obtain a copy of the Flexible Spending Account claim form at the Pilkington North America Human Resources intranet site.

Claim forms and additional information may also be found at http://mybenefits.conexis.com Complete the form, and fax it with the appropriate documentation to:

**CONEXIS Claim Administration**
**1-888-866-3312**

The CONEXIS participant services phone number is **(866) 279-8385**.

PRE-TAX ACCOUNT STATEMENTS

If you participate in the pre-tax Health Care Reimbursement Account Program, you will receive a summary of your account balance with each reimbursement.

REMAINING PRE-TAX ACCOUNT BALANCES

At the close of the Extended Plan year, any funds remaining in your account are forfeited. Under IRS regulations, the company may not return any forfeited specific dollar amounts back to individual accounts.

TERMINATION, RETIREMENT, OR DEATH AND YOUR PRE-TAX ACCOUNT

If you are terminated or you retire, you may submit expenses through April 30 of the Extended Plan year providing that such expenses were incurred during the Plan year when you were a Participant and that the expenses conform in all other respects to the requirements of the Plan. In the event of your death, your executor may submit expenses through April 30 of the Extended Plan year with the same stipulations outlined for those who retire.

TAX CONSEQUENCES

Expenses which are reimbursed through the Health Care Reimbursement Account are considered tax-free for federal tax purposes, but may be taxable for state or local purposes. Pilkington North America and the Plan Administrator cannot and do not guarantee that the Internal Revenue Service will not challenge you if such expenses are found not to be for medical care. Any tax you would owe on account of such reimbursements, together with any applicable penalties and interest, are your sole responsibility.

FOR EXAMPLE...

The following is an illustration of what tax savings might be available to an employee using this Pre-tax Reimbursement Account. (Individual savings will depend on your personal situation, number of dependents, state of residence, etc.)

Assumptions: annual income of $30,000 and
anticipated personal medical expenses of $500.

THE CHOICE IS YOURS

| | No Pre-tax Account | With Pre-tax Account |
|---|---|---|
| Anticipated Medical Expenses | $500 | $500 |
| Federal Tax | 75 | -0- |
| State Tax | 14 | -0- |
| FICA (Social Security) | 38 | -0- |
| What you must earn to cover your medical expenses: | $627 | $500 |

Potential tax savings by using pre-tax account: $127

## F. 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**
In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of 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 and the laws listed below are addressed in the following sections.

- Certification Of Health Care Coverage
- Claims Appeals Procedures
- Confidentiality Of Personal Health Information
- Continuation Of Coverage (COBRA)
- Family And Medical Leave Act Of 1993
- Genetic Information Nondiscrimination Act of 2008
- Health Insurance Portability and Accountability Act Of 1996 (HIPAA) And American Recovery And Reinvestment Act Of 2009 (ARRA)
- Material Reductions in Covered Services or Benefits
- Maternity Hospital Stay
- State Child Health Insurance Program (SCHIP)
- Uniformed Services Employment And Re-Employment Rights
- Women's Health And Cancer Rights Act Of 1998 (WHCRA)

There is additional 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 and appeals procedures which are part of the Pilkington North America Health and Welfare Program (the Program). 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 with Aetna, Blue Cross Blue Shield (Illinois), Blue Cross Blue Shield (Michigan), Blue Grass Family Health, CIGNA HealthCare, Express Scripts Inc., or Paramount. Claims Administrators for the various health care plans are shown in the section entitled "Plan Information". Individual Claim Administrators may allow additional time for filing an appeal. Please call your Claim Administrator for additional questions.

Please note: other carriers providing fully insured coverage may not be 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 and appeal procedures.

## Eligibility Appeal Procedures

All appeals regarding employee/retiree or dependent eligibility must be sent in writing to the Plan Administrator. You will be notified in writing or electronically within 60 days after receipt of your appeal if you have been approved in whole or in part.

Eligibility appeals may be mailed to the following address:

**Pilkington North America, Inc.**
**Attn: Secretary of Welfare Plan Committee**
**P.O. Box 925**
**Toledo, OH 43697-0925**

Eligibility appeals may be faxed to the following mailbox:

**PNA.BenefitsCenter@nsg.com**

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.

## Claims Procedures

### Submitting a Healthcare Claim

Initial claims for benefits are made to the Claims Administrator. The Claims Administrator for each plan is specified in the section entitled "Healthcare Plan Information". 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 12 months after the date of service. (For example, if you or your dependent obtains a medical service on a certain date, you have

until 12 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, as soon as possible, taking into account the medical exigencies but no later than 72 hours after receiving your claim.

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** For pre-service claims, 15 days after receiving your claim.

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.

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.

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** 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.

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 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 coverage), 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 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).

### Internal Appeals Procedures

In general, the Plan Administrator has delegated to each Claims Administrator the obligation of deciding first and second level (where applicable) internal 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 **Pre-service** or **Post-service** claims in writing within 180 days of receiving notification. **Urgent care** claims appeals may be requested orally and all necessary information, including the decision on review, may be transmitted by telephone, facsimile, or other available similarly expeditious methods. The deadline to appeal your **Concurrent Care** claims appeal will depend on whether your claim for an extension is considered to be an urgent, pre-service or post-service claim.

**Level-One Appeals** will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

**Level-Two Appeals** regarding the medical necessity or clinical appropriateness will be conducted by a Committee which consists of one or more people not previously involved in the prior decision. The Committee will consult with at least one Physician in the same or similar specialty as the care under consideration.

**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 and receive a review of the determination that takes into account information submitted whether or not it was considered in the initial benefit determination;
- May request free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- 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

**Notification of Internal Appeal Determinations by the 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:

**Pre-Service or Concurrent Care Claims Appeals** determinations will be completed within 15 days. **Post-Service Claims Appeals** determinations will be completed within 30 days. If more time or information is needed the Claim Administrator will notify you in writing to request an extension of up to 15 days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited appeal would be detrimental to your medical condition.

The Claims Administrator's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, the Claim Administrator will respond orally with a decision within 72 hours, followed up in writing.

In the event any new or additional information (evidence) is considered, relied upon or generated by the Claims Administrator in connection with the level-two appeal, the Claims Administrator will provide this information to you as soon as possible and sufficiently in advance of the Committee's decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the Claims Administrator, they will provide the rationale to you as soon as possible and sufficiently in advance of the Committee's decision so that you will have an opportunity to respond.

**If Your Internal 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).

## External Reviews Procedure

In general, the Plan Administrator has delegated to each Claims Administrator the obligation of facilitating third-level (external) 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.

**The Standard External Review for Self-Insured Group Health Plans**

This section sets forth procedures for **standard** external review for self-insured group health plans. Individual Claims Administrators may allow additional time for filing a request for external review. Please call your Claims Administrator with any additional questions.

Standard external review is an external review that is not considered expedited (as described below).

- Request for external review. A group health plan must allow a claimant to file a request for an external review with the plan if the request is filed within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

- Preliminary review. Within five business days following the date of receipt of the

external review request, the group health plan must complete a preliminary review of the request to determine whether:

- The claimant is or was covered under the plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the plan at the time the health care item or service was provided;

- The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

- The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

- The claimant has provided all the information and forms required to process an external review.

  Within one business day after completion of the preliminary review, the plan must issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification must describe the information or materials needed to make the request complete and the plan must allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

- Referral to Independent Review Organization. The group health plan (through its Claims Administrator) will assign an independent review organization (IRO) that is accredited by URAC or by similar nationally-recognized accrediting organization to conduct the external review. Moreover, the plan will (also through its Claims Administrator) take action against bias and to ensure independence. Accordingly, plans (or their Claims Administrators if so designated) must contract with at least (3) IROs for assignments under the plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

  A contract between a plan (in most cases through its Claims Administrator) and an IRO must provide the following:

  - The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the plan.

  - The assigned IRO will timely notify the claimant in writing of the request eligibility and acceptance for external review. This notice will include a statement that the

claimant may submit in writing to the assigned IRO within two business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after ten business days.

- Within five business days after the date of assignment of the IRO, the plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the plan to timely provide the documents and information must not delay the conduct of the external review. If the plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination. Within one business day after making the decision, the IRO must notify the claimant and the plan.

- Upon receipt of any information submitted by the claimant, the assigned IRO must within one business day forward the information to the plan. Upon receipt of any such information, the plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one business day after making such a decision, the plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the plan.

- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the plan's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the PHS Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:
  - The claimant's medical records;
  - The attending health care professional's recommendation;
  - Reports from appropriate health care professionals and other documents;
  - The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the plan, unless the terms are inconsistent with applicable law;
  - Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

- Any applicable clinical review criteria developed and used by the plan, the criteria are inconsistent with the terms of the plan or with applicable law; and
- The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

° The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the plan.

° The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial);
- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;
- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available under tort or Federal law to either the group health plan or to the claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

° After a final external review decision, the IRO must maintain records of all claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the claimant, plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

- Reversal of plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the plan (through its Claims Administrator) must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

**The Expedited External Review for Self-Insured Group Health Plans**

- Request for expedited external review. A group health plan (or if so designated, the Plan's Claims Administrator) must allow a claimant to make a request for an expedited external review at the time the claimant receives:

  - An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

  - A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

- Preliminary review. Immediately upon receipt of the request for expedited external review, the plan must determine whether the request meets the reviewability requirements set forth above for standard external review. The plan must immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

- Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the plan will assign an IRO pursuant to the requirements set forth above for stand review. The plan must provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

  The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the plan's internal claims and appeals process.

- Notice of final external review decision. The plan's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and to the plan.

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, Prescription Drug, Dental, Vision, and/or Health Care Flexible Spending Arrangement (FSA) 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 coverage the Plan should provide. The Plan may remove information that identifies you from health information disclosed to the Company so it may be used without the Company learning the identity of specific participants. To the extent that the Plan intends to use or disclose your Protected Health Information for underwriting purposes, the Plan is prohibited from using or disclosing genetic information about an individual for such purposes.

**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 Administrative 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 committeed 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 U.S. 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.

**Inmates**. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plan may disclose your PHI to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institution.

**REQUIRED DISCLOSURES**

**Governmental Audits.** The Plan is required to disclose your PHI to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

**Disclosures to You**. When you request, the Plan is required to disclose to you the portion of your PHI that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your PHI if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the PHI was not disclosed pursuant to your individual authorization.

**OTHER DISCLOSURES**

**Personal Representatives.** The Plan will disclose your PHI to individuals authorized by you, or to an individual designated by you as your personal representative, attorney-in-fact, etc. so long as you provide the Plan with a written notice/authorization and any supporting documents (i.e. power of attorney).

**Spouses and Other Family Members.** With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members.

**Authorizations.** The following uses or disclosures of your PHI will be made only with your written authorization: (1) most uses and disclosures of psychotherapy notes, (2) uses and disclosures of PHI for marketing purposes, (3) disclosures that constitute a sale of PHI and (4) other uses or disclosures of your PHI not described in this notice. You may revoke written authorization at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will be effective only for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

**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. The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you for the costs of providing the list. We will notify you of the cost involved (if any) and you may choose to withdraw or modify your request at that time before any costs are incurred. Your request should indicate in what form you want the list (for example, paper or electronic).

**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. However, if the Plan does agree to the request, it will honor the restriction until you revoke it or the Plan notifies you.***

Effective February 17, 2010 (or such other date specified as the effective date under applicable law), the Plan will comply with any restriction request if: (1) except as otherwise required by law, the disclosure is to the Plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

**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 be Notified of a Breach**. You have the right to be notified in the event that the Plan (or a business associate) discovers a breach of unsecured PHI.

**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 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.*

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**
**Notice Effective Date: May 15, 2013**

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 "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 the coverage included dental coverage, the person may purchase medical and dental, medical only, or dental only. 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 active employees 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.

**GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS**
**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

**Introduction**

You are receiving this notice because you are eligible for coverage under a Pilkington North America group health plan (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 an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, 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 any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- 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. or Pilkington Holdings, 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 employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

### You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee 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 by entering the information on the benefits website at **https://pna.employee.com** ; by talking to a Pilkington Benefits Center representative at **(800) 685-4335** (in the Toledo area **(419) 247-4714**) between 8 am and 5 pm Eastern time Monday through Friday (except holidays); or by writing to the following address:

**Pilkington Benefits Center**
**P.O. Box 925**
**Toledo, OH 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 employees 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 employee, the employee'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.
Notice of the disability must be given to the Plan's COBRA Administrator within 60 days of the date of the Social Security Administration determination and before the end of the 18-month period of COBRA continuation coverage. The notice must be sent to:

**CONEXIS**
**P.O. Box 226101**
**Dallas TX 75222**

*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, notify the Plan's COBRA Administrator within 60 days of the qualifying event by writing to the following address:

**CONEXIS**
**P.O. Box 226101**
**Dallas TX 75222**

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

### If You Have Questions

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 may be directed to either the Pilkington North America Benefits Center at **(800) 685-4335**, or to the COBRA Administrator at **(877) 722-2667**. COBRA appeals may be mailed to:

**CONEXIS**
**Attn: Written Correspondence Dept.**
**P.O. Box 227197**
**Dallas TX 75222**

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 visit the EBSA website at **www.dol.gov/ebsa** . (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's 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

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

**Pilkington North America Healthcare Plan Administrator**
**Pilkington North America Benefits Center**
**P.O. Box 925**
**Toledo, OH 43697-0925**

FAMILY AND MEDICAL LEAVE ACT OF 1993

Any provisions of the plan that provide for: (a) continuation of coverage during a leave of absence; and (b) reinstatement of coverage following a return to Active Service; are modified by the following provisions of the federal Family and Medical Leave Act of 1993, where applicable.

**Continuation of Health Coverage during Family Leave**

Your health coverage will be continued during a leave of absence if:

- that leave qualifies as a leave of absence under the Family and Medical Leave Act of 1993; and
- you are an eligible Employee under the terms of that Act.

The cost of your health coverage during such leave must be paid, in part by you and by the Company.

**Reinstatement of Canceled Coverage Following Family Leave**

Upon your return to Active Service following a leave of absence that qualifies under the Family and Medical Leave Act of 1993, any canceled coverage (health, life or disability) will be reinstated as of the first of the month following the date of your return. You will not be required to satisfy any eligibility or benefit waiting period or the requirements of any *Pre-existing Condition Limitation* to the extent that they had been satisfied prior to the start of such leave of absence.

GENETIC NON-DISCRIMINATION ACT of 2008

The Genetic Information Nondiscrimination Act (GINA) was signed into law by President George W. Bush on May 21, 2008. The law clarifies that genetic information is "protected health information" under the HIPAA law. The law prohibits employers and group health plans from discriminating on the basis of genetic information and limits the collection of such information by employers and group health plans.

The law:

- Prohibits the restriction of health care plan enrollment on the basis of genetic information or genetic services;
- Prohibits the adjustment of plan participant healthcare contributions and premiums on the basis of genetic information or genetic services;
- Prevents health plans and insurers from requesting or requiring that an individual take a genetic test; and
- Covers all types of health plans, including those regulated by ERISA, state-regulated plans, and individual market health plans.

GINA amended ERISA to allow the labor secretary to impose penalties for the improper use of genetic information by a group health plan. The law defines genetic information as:

- A plan participant's genetic tests,
- Genetic tests of the plan participant's family members,

- The "manifestation of a disease or disorder" in the plan participant's family members. Family members include dependents and any other individual who is a first, second, third, or fourth degree relative of the plan participant or the plan participant's dependent.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) and AMERICAN RECOVERY AND REINVESTMENT ACT OF 2009 (ARRA)

In 1996 HIPAA initially provided for limits on preexisting conditions and discrimination based on health condition. Title II of HIPAA later introduced protection of individually identifiable health information (PHI). In 2009, ARRA expanded the scope of HIPAA privacy and security rules to include notification requirements for breaches of security.

The plans covered include medical including prescription drugs, dental, mental health /substance abuse, vision, employee assistance, health care flexible spending accounts (FSAs), and bona fide wellness programs.

PHI is individually identifiable health information, transmitted or maintained in any form or medium, which:

- relates to the provision of health care to an individual or the past, present, or future payment for health care services;
- identifies the individual or can be used to identify the individual; or
- is created or received by a health care provider, health plan, or health care clearinghouse.

PHI does not include

- "De-identified" or summary information,
- Eligibility data
- Employment records held by an employer (e.g., FMLA/ADA administration, sick leave requests, drug screening, fitness for duty exams, disability insurance eligibility)

If the Company uses outside vendors to provide benefits, claim administration, or transmit data, each of those vendors is considered to be a Business Associates (BA) which is also subject to HIPAA. Effective February 17, 2010 each BA will be required to implement administrative, physical, and technical safeguards to protect and control access to ePHI and implement appropriate policies and procedures to maintain proper documentation.

Pilkington has the right to disclose PHI to Business Associates for purposes of benefits administration. Each plan participant has the right to inspect, correct, or restrict the use of PHI. Upon proper request, Covered Entities using electronic health records must provide individuals with an electronic copy of the individual's records containing PHI. The Covered Entity cannot charge the individual any more than the actual labor costs to provide this service.

Effective August 17, 2009, it became mandatory for the Covered Entity to notify individuals and the federal Department of Health and Human Services upon discovery of a "breach" of

unsecured PHI. "Breach" is the unauthorized acquisition, access, use, or disclosure of PHI which compromises the security or privacy of such information.

If a participant in a covered PNA plan would like to inspect, correct, or restrict the use of PHI, or report a suspected breach of the security of PHI, please contact the Plan Administrator or Agent for Service of Legal Process. (Contact information is shown later in this Summary Plan Description.)

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.

STATE CHILD HEALTH INSURANCE PROGRAM (SCHIP)

The American Reinvestment and Recovery Act (ARRA), also known as the Economic Stimulus Package, was signed into law on February 17, 2009. As part of ARRA and subsequent legislation, important changes have been made to individual State Health Insurance programs which offer free or low-cost coverage for children and families.

*Note: If you do not have children, you can disregard this message.*

**Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)**

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs

to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

**If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2013. You should contact your State for further information on eligibility –**

<table>
<tr><td>ALABAMA – Medicaid</td><td>COLORADO – Medicaid</td></tr>
<tr><td>Website: http://www.medicaid.alabama.gov<br>Phone: 1-855-692-5447</td><td rowspan="2">Medicaid Website: http://www.colorado.gov/<br><br>Medicaid Phone (In state): 1-800-866-3513<br>Medicaid Phone (Out of state): 1-800-221-3943</td></tr>
<tr><td>ALASKA – Medicaid</td></tr>
<tr><td>Website:<br>http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone (Outside of Anchorage): 1-888-318-8890<br>Phone (Anchorage): 907-269-6529</td><td></td></tr>
<tr><td>ARIZONA – CHIP</td><td>FLORIDA – Medicaid</td></tr>
<tr><td rowspan="3">Website: http://www.azahcccs.gov/applicants<br>Phone (Outside of Maricopa County): 1-877-764-5437<br>Phone (Maricopa County): 602-417-5437</td><td>Website: https://www.flmedicaidtplrecovery.com/<br>Phone: 1-877-357-3268</td></tr>
<tr><td>GEORGIA – Medicaid</td></tr>
<tr><td>Website: http://dch.georgia.gov/<br>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)<br>Phone: 1-800-869-1150</td></tr>
</table>

| **IDAHO** – Medicaid and CHIP | **MONTANA** – Medicaid |
|---|---|
| Medicaid Website:<br>www.accesstohealthinsurance.idaho.gov<br>Medicaid Phone: 1-800-926-2588<br>CHIP Website: www.medicaid.idaho.gov<br>CHIP Phone: 1-800-926-2588 | Website:<br>http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br>Phone: 1-800-694-3084 |
| **INDIANA** – Medicaid | **NEBRASKA** – Medicaid |
| Website: http://www.in.gov/fssa<br>Phone: 1-800-889-9949 | Website: www.ACCESSNebraska.ne.gov<br>Phone: 1-800-383-4278 |
| **IOWA** – Medicaid | **NEVADA** – Medicaid |
| Website: www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 | Medicaid Website: http://dwss.nv.gov/<br><br>Medicaid Phone: 1-800-992-0900 |
| **KANSAS** – Medicaid | |
| Website: http://www.kdheks.gov/hcf/<br>Phone: 1-800-792-4884 | |
| **KENTUCKY** – Medicaid | **NEW HAMPSHIRE** – Medicaid |
| Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | Website:<br>http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 603-271-5218 |
| **LOUISIANA** – Medicaid | **NEW JERSEY** – Medicaid and CHIP |
| Website: http://www.lahipp.dhh.louisiana.gov<br>Phone: 1-888-695-2447 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website:<br>http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MAINE –** Medicaid | |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-977-6740<br>TTY 1-800-977-6741 | |
| **MASSACHUSETTS** – Medicaid and CHIP | **NEW YORK –** Medicaid |
| Website: http://www.mass.gov/MassHealth<br>Phone: 1-800-462-1120 | Website:<br>http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA** – Medicaid | **NORTH CAROLINA** – Medicaid |
| Website: http://www.dhs.state.mn.us/<br>Click on Health Care, then Medical Assistance<br>Phone: 1-800-657-3629 | Website: http://www.ncdhhs.gov/dma<br>Phone: 919-855-4100 |
| **MISSOURI** – Medicaid | **NORTH DAKOTA** – Medicaid |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-800-755-2604 |
| **OKLAHOMA** – Medicaid and CHIP | **UTAH** – Medicaid and CHIP |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Website: http://health.utah.gov/upp<br>Phone: 1-866-435-7414 |

| **OREGON** – Medicaid and CHIP | **VERMONT**– Medicaid |
|---|---|
| Website: http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA** – Medicaid | **VIRGINIA** – Medicaid and CHIP |
| Website: http://www.dpw.state.pa.us/hipp<br>Phone: 1-800-692-7462 | Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website: http://www.famis.org/<br>CHIP Phone: 1-866-873-2647 |
| **RHODE ISLAND** – Medicaid | **WASHINGTON** – Medicaid |
| Website: www.ohhs.ri.gov<br><br>Phone: 401-462-5300 | Website:<br>http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm<br>Phone: 1-800-562-3022 ext. 15473 |
| **SOUTH CAROLINA** – Medicaid | **WEST VIRGINIA** – Medicaid |
| Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: www.dhhr.wv.gov/bms/<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **SOUTH DAKOTA** - Medicaid | **WISCONSIN** – Medicaid |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website: http://www.badgercareplus.org/pubs/p-10095.htm<br>Phone: 1-800-362-3002 |
| **TEXAS** – Medicaid | **WYOMING** – Medicaid |
| Website: https://www.gethipptexas.com/<br>Phone: 1-800-440-0493 | Website:<br>http://health.wyo.gov/healthcarefin/equalitycare<br>Phone: 307-777-7531 |

To see if any more States have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Services
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)
61565

U.S. Department of Health and Human

Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext.

OMB Control Number 1210-0137 (expires 10/31/2016)

UNIFORMED SERVICES EMPLOYMENT AND RE-EMPLOYMENT RIGHTS

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) sets requirements for continuation of health coverage and reemployment in regard to military leaves of absence. These requirements apply to medical coverage for employees who enter one of the Uniformed Services of the United States, and their Dependents.

**Continuation of Coverage during Military Service**

- For leaves of less than 31 days, coverage will continue as described in the Termination section regarding Leave of Absence.
- For leaves of 31 days or more, you may continue coverage for yourself and your Dependents according to the federal continuation benefits specified under COBRA.
- Your Employer may charge you and your Dependents up to 102% of the total amount of coverage.
- Following continuation of health coverage per COBRA or USERRA requirements, there are no conversion privileges.

**Reinstatement of Benefits**

If your coverage ends during the leave because you do not elect COBRA, and you are re-employed by your current Employer, coverage for you and your Dependents may be reinstated if a) you gave your Employer advance written or verbal notice of your military service leave, and b) the duration of all military leaves while you are employed with your current Employer does not exceed 5 years.

**Time Frames for Requesting Re-Employment**

When a leave ends, you must report your intent to return to work as follows:

- For leaves of less than 31 days or for a fitness exam, by reporting to your Employer by the next regularly scheduled work day following 8 hours of travel time;
- For leaves of 31 days or more but less than 181 days, by submitting an application to your Employer within 14 days; and
- For leaves of more than 180 days, by submitting an application to your Employer within 90 days.

Consult your Human Resources representative for more details regarding your rights and your Employer's obligations for re-employment.

## HEALTHCARE PLAN INFORMATION

| | | |
|---|---|---|
| **Plan Names** | Pilkington North America, Inc. Group Health Care Program, composed of the following sub-plans:<br>- Medical Plan (which includes prescription drug and mental health and chemical dependency benefits)<br>- Dental Plan<br>- Vision Plan | |
| **Employer** | Pilkington North America, Inc.<br>P.O. Box 799<br>Toledo, OH 43697-0799 | (419) 247-3731<br>Employer ID #34-1506654 |
| **Plan Sponsor** | Pilkington North America, Inc.<br>P.O. Box 925<br>Toledo, OH 43697-0925 | (800) 685-4335 |
| **Plan Administrator** | Welfare Plans Committee<br>Pilkington North America, Inc.<br>P.O. Box 925 | (800) 685-4335 |

| | | |
|---|---|---|
| | Toledo, OH 43697-0925 | |
| **Agent for Service of Legal Process**<br>(Legal process may also be served on the Plan Administrator or a Plan trustee) | Office of General Counsel<br>Pilkington North America, Inc.<br>P.O. Box 799<br>Toledo, OH 43697-0799 | (419) 247-3731 |
| **Plan Year** | Calendar year (January 1 through December 31) | |

## 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 Plus | CIGNA HealthCare | **Claims:** CIGNA HealthCare<br>P.O. Box 182223<br>Chattanooga, TN 37422-7223<br><br>**Appeals:** CIGNA HealthCare<br>**National Appeal Unit**<br>PO Box 188011<br>Chattanooga, TN 37422<br><br>**Contact information:**<br>Member Services (800) 244-6224<br><br>**Administration appeals:**<br>Pilkington North America<br>Welfare Plans Committee<br>811 Madison Ave. P.O. Box 925<br>Toledo, OH 43697-0925<br><br>Benefits Center: (800) 685-4335 |

| | | |
|---|---|---|
| Prescription Drug benefits | Express Scripts, Inc. | **Internal and external appeals**:<br>**Express Scripts, Inc.**<br>P.O. Box 631850<br>Irving, TX 75063-0030<br><br>Member Services (800) 417-1916<br><br>**Administration appeals:**<br>Pilkington North America<br>Welfare Plans Committee<br>811 Madison Ave. P.O. Box 925<br>Toledo, OH 43697-0925<br><br>Benefits Center: (800) 685-4335 |

**DENTAL PLAN CONTACT INFORMATION**

| | | |
|---|---|---|
| **Type of Plan** | Welfare: dental | |
| **Plan Number** | 502 | |
| **Financial Facts** | **Self-funded** | |
| **Claims Administrator** | **Claims and appeals** | CIGNA<br>PO Box 188037<br>Chattanooga, TN 37422-8037 |
| | **Contact information:** | (800) 244-6224 |

**VISION PLAN CONTACT INFORMATION**

| | | |
|---|---|---|
| **Type of Plan** | Welfare: Vision | |
| **Plan Number** | 504 | |
| **Financial Facts** | Insured | |
| **Claims Administrator** | Claims and appeals: | United Healthcare Vision<br>P.O. Box 30978<br>Salt Lake City, Utah 84130 |
| | Member Services: | (800) 839-3242 |

## 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.

| **Alternative Plan Sponsor:** | **Contact Information:** |
|---|---|
| Insurer –<br>**Kaiser Permanente (Lathrop)** | **Claim Appeals:** Kaiser Foundation Health Plan<br>Claims Department<br>P.O. Box 12923<br>Oakland, CA 94604-2923<br><br>**Contact information:**<br>Member Services (800) 464-4000<br>(800) 390-3510 |
| Claims Administrator –<br>**Blue Cross Blue Shield of Illinois (Ottawa) *** | **Claims:** Blue Cross Blue Shield of Illinois<br>Quincy Full Service Unit<br>1400 North 30th Street<br>Quincy, IL 62301<br><br>**Appeals Address:** Blue Cross Blue Shield of Illinois<br>Quincy Full Service Unit<br>1400 North 30th Street<br>Quincy, IL 62301<br><br>**Customer Service:** (800) 828-3116<br><br>**Website:** www.bcbsil.com |

*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.)

## G. ABOUT THIS SUMMARY PLAN DESCRIPTION

This Healthcare document 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 describes the following Plans as they apply to eligible employees of the Company and their covered dependents:

- This Company healthcare Plan, which includes the:
  - Medical Plan benefits
  - Mental Health and Chemical Dependency benefits
  - Prescription Drug benefits
- The Company Dental Plan

- The Company Vision Plan.

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.

## H. 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 Center at **(800) 685-4335** or in the Toledo area (**419) 247-4714**.

## I. DEFINITIONS

The Health and Human Services department has developed a Glossary of Standard Terms used in Health insurance coverage. It can be found on the PNA web-site at **https://pna.emolyee.com.** Their glossary is intended to be educational and may be different from the terms and definitions in your Plan as outlined in the Summary Plan Description and Plan document. In such cases, the Plan governs.

### ALTERNATIVE HEALTH PLANS

In some locations, other HMO or EPO medical plans may be available. If you have chosen one of these other medical plans, the benefits available through that plan are not described in this booklet. Because of the wide variety of managed care systems, benefits obtained from such alternative plans 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 other Company-sponsored alternative plans.

**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.

**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 employee. See eligibility and termination sections for details.

**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.

**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.

**EMPLOYEE**
An employee eligible to participate is
- a regular full-time hourly employee of either the Pilkington North America, Inc. Ottawa, Illinois Plant represented by The United Steelworkers of America, AFL-CIO, CLC, Local 19G, or of the Lathrop, California Plant represented by The United Steelworkers of America, AFL-CIO, CLC, Local 418G,

- upon the first of the month following two full months of employment not to exceed 90 days provided the employee is actively employed on that date and has completed the enrollment process necessary to enroll in such programs. If the employee is not actively at work, coverage will be effective on the first of the month following the day the employee returns to work on a full-time basis.

**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.

- 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 employee 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.

**EMERGENCY SERVICES**
Emergency services are medical, psychiatric, surgical, Hospital and related healthcare services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily injury or serious sickness which could reasonably be expected by a prudent lay person to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones.

**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, Dental Plan, Prescription Drug Plan, Mental Health and Chemical Dependency Plan, and/or Vision 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 employee, birth or adoption of a dependent, gain or loss of a dependent through legal custody proceedings, death of the employee or the spouse or dependent of the employee, divorce of the employee, or gain
or loss of employment by the employee or the Spouse of the employee, 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.

**LIFETIME MAXIMUM**
The medical lifetime limit on the dollar value of benefits under the Pilkington North America Inc. Health and Welfare Plan no longer applies. For more information contact the PNA Benefits Center at (800) 685-4335. The Toledo area local number of the Benefits Center is (419) 247-4714.

**MANAGED CARE PROGRAMS**
Company authorized and approved Managed Care Programs may be available at certain Company locations. These are known as Open Access Programs (OAP), Preferred Provider Organizations (PPO), Health Maintenance Organizations (HMO), or Exclusive Provider Organizations (EPO).

While their actual structures may vary, OAPs and PPOs generally offer medical and/or dental services from a "preferred" network of health care providers on a fee-for-service basis; that is, payment is made based on the medical or dental 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.

Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) 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 fee equal to the cost of providing the Company Plan (but not exceeding the cost of HMO participation) and the employee pays a contribution of the balance (but not less than that for the Company Plan). An EPO is a self-insured HMO. The Company pays all costs and claims of an EPO, less any contribution made by the employee.

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 OAPs, 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.

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.

Services are not covered if they are custodial, training, educational or developmental in nature.
To be covered all therapy services must be restorative in nature.

- Restorative Therapy services are services that are designed to restore levels of function that had previously existed but that have been lost as a result of Injury or Sickness.
- Restorative Therapy services do not include therapy designed to acquire levels of function that had not been previously achieved prior to the Injury or Sickness.

After meeting the above criteria, 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:

- Prescription co-payments or co-insurance
- Dental Plan co-insurance

- Orthodontic co-insurance,
- Any amounts over the dental lifetime maximum.
- 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.

**PARTICIPANT**
A participant is an employee, Spouse, or dependent of an employee 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.

**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 *employee*, but who is not eligible to participate in this benefit plan.

**SPOUSE**
With respect to an employee, a person to whom the employee is legally married as evidenced by the issuance of a marriage certificate by a governmental authority, including marriages entered into in a state whose laws authorize the marriage of two individuals of the same sex. It does not include individuals (whether of the opposite sex or same sex) who have entered into a registered domestic partnership, civil union or other similar formal relationship recognized under state law that is not denominated a marriage under the laws of that state. Common-law spouses enrolled prior to July 1, 2010 are grandfathered as eligible as long as they can provide evidence of such common-law marriage. The employee may be required to produce evidence of any marriage (e.g. a federal tax return showing married status).

**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 |
| Mental Health and Chemical Dependency benefits | CIGNA |
| Prescription drug benefits | Express Scripts, Inc. |
| Dental Plan | CIGNA |
| Vision Plan | United Healthcare Vision |
| Blue Cross Blue Shield of Illinois PPO (Ottawa only) | Blue Cross and Blue Shield of Illinois |
| Kaiser HMO (Lathrop only) | Kaiser |

*CIGNA is available to all participating employees. Other options depend on what the Company has made available at your work location. See the section on Alternative Plans for more information on your options.

## J. INDEX

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***R***



***S***

***T***



***V***



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