2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

NOTE TO USER: Any words that are italicized such as The Employee Service Center, will be found in the back of this document under Contacts. The Glossary Section that is found in the back of this document contains definitions of italicized

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UHC Base - Retiree/National Surviving Spouse

UHC Base Plan-Retiree

The UHC Base Plan provides coverage for retirees and their eligible dependents. Once you satisfy an annual deductible, the Plan pays 80% of reasonable and customary expenses. Once your expenses reach the out-of-pocket maximum, the Plan then pays 100% of most remaining reasonable and customary expenses for the rest of the calendar year.

A prescription medication program is also included which allows you to purchase prescriptions at retail pharmacies and through a home delivery program. There is only one card to be used for medical services and prescriptions.

UHC Base Plan-National Surviving Spouse

Procter & Gamble also offers the identical medical plan with the identical coverage to surviving spouses as it does to retirees, with the following differences:

- Plan costs are totally paid by the surviving spouse;
- Dependents of surviving spouses are not eligible for the National Surviving Spouse plan;
- Customer service (enrollment, eligibility, questions, change of address, etc) is provided by Fiserv Health( not the Employee Service Center), which is the same organization that collects premiums for Retiree Health Care.
Benefit Amount (What’s Covered)

Procter & Gamble provides high quality medical coverage to you and your eligible dependents. Under the Plan, you share in paying your medical expenses through deductibles and coinsurance. These deductible and coinsurance amounts apply to all eligible expenses.

After you satisfy your deductible, the Plan reimburses 80% of eligible expenses and you pay the remaining 20% coinsurance. To protect you from large medical bills, it limits your out-of-pocket covered medical expenses.

Your benefits are subject to certain annual and out-of-pocket maximums.

The Plan also includes certain coverage limitations and exclusions.

Coverage Information

The following is a list of services covered under this Plan. However, not all covered items are listed. Check with the Plan to confirm whether a particular service is covered.

Certain services require Notification/Authorization before benefits will be provided. Services listed under the Home Care, Hospice Care and Inpatient Hospitalization sections require notification/authorization by event, not by individual service. For example, Inpatient Hospitalization requires one Notification/Authorization - separate notifications/authorizations would not be required for x-rays or lab tests, etc., during that hospitalization.
## COVERAGE INFORMATION OVERVIEW

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Annual Deductible                                                          | $100/Person  
$200/Family                                                                                                                                 |
| Annual Out-of-Pocket Maximum                                               | **Maximum:**  
$1,575/Person or Family  
The following apply to the out-of-pocket maximum:  
*co-insurance (except behavioral health, out-of-Organ Transplant Network-organ transplants and retail/home delivery prescription medications),  
*deductibles.                                                                                                                                 |
| Emergency Room Care for a Sudden Serious Illness or Injury that Requires Hospital Services | For emergency conditions only. No coverage for non-emergency use of ER.  
80% of covered charges after annual deductible.                                    |
| Hospital Care - Inpatient                                                  | **Notification required.**  
80% of covered charges after annual deductible.                                                                                         |
| Hospital Care - Outpatient - Non-Surgery                                   | 80% of covered charges after annual deductible.                                                                                         |
| Hospital Care - Outpatient - Surgery                                       | 80% of covered charges after annual deductible.                                                                                         |
| Lifetime Maximum Benefit                                                   | **Maximum:**  
Unlimited. Benefit-specific limits may apply.                                                                                          |
<table>
<thead>
<tr>
<th>Organ Transplants</th>
<th>Pre-transplant notification required.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100% of covered charges after annual deductible if Organ Transplant network is used. 80% of covered charges after annual deductible if Organ Transplant network is not used and there is no out-of-pocket maximum.</td>
</tr>
<tr>
<td>Includes:</td>
<td>INCLUDES: Bone Marrow - Allogeneic for certain diagnosis, Bone Marrow - Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel.</td>
</tr>
<tr>
<td></td>
<td>Any transplant not listed above required by state or federal law.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physician Office Visit - Generalist</th>
<th>80% of covered charges after annual deductible.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Office Visit - Specialist</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Prescription Medications</td>
<td>Retail: 100% of covered charges after 30% co-insurance per person per prescription.</td>
</tr>
<tr>
<td></td>
<td><strong>Home Delivery (Mail Order):</strong> 100% of covered charges after 30% co-insurance per prescription.</td>
</tr>
<tr>
<td></td>
<td>Maximum: 34-days supply for Retail. 120 days supply for Home Delivery. Maximum: $1,500 out-of-pocket maximum per person or family per plan year.</td>
</tr>
</tbody>
</table>

| Prescription Medications - Where Over-The-Counter (OTC) Equivalents Are Available (Medications that can be obtained without a prescription and are considered by pharmacists and other specialists to be equivalent to certain prescription medications) | Retail: 100% of covered charges after 50% co-insurance per person per prescription. |
|                                                  | **Home Delivery (Mail Order):** 100% of covered charges after 50% co-insurance per prescription. |
|                                                  | Maximum: 34-days supply for Retail. 120 days supply for Home Delivery. |

| Therapy - Occupational                           | 80% of covered charges after annual deductible. |
|                                                  | **Maximum:** 20 visit limit per person per plan year. Limit applies to all occupational therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization. |
| Therapy - Physical | 80% of covered charges after annual deductible.  
|                   | **Maximum**: 30 visit limit per person per plan year. Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization. |
| Therapy - Speech  | 80% of covered charges after annual deductible.  
|                   | **Maximum**: 20 visit limit per person per plan year. Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization. |
| Urgent Care Center| 80% of covered charges after annual deductible. |

### BEHAVIORAL HEALTH TREATMENT

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Inpatient Services   | **Notification required.**  
|                      | 80% of covered charges after annual deductible.       |
| **Outpatient Services** | 50% of covered charges after annual deductible. | **Maximum:** $100 charge or $50 payment per visit, 50 visits per person per plan year. |

**DENTAL TREATMENT**

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th><strong>Benefits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Care &amp; Anesthesia - Routine</td>
<td>Covered under dental plan.</td>
</tr>
<tr>
<td>Medical Facility Charges When Hospitalization is Required for Covered Dental Services</td>
<td>Notification required. Medical (Not Dental) Necessity Applies. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Office Dental Treatment of Traumatic Accidental Injury to Natural Teeth, e.g. auto accident, fall, etc.</td>
<td>Notification required. Medical (Not Dental) Necessity Applies. 80% of covered charges after annual deductible. Includes replacement of natural teeth. Treatment must occur within 12 months of injury.</td>
</tr>
<tr>
<td>TMJ - Physician Services</td>
<td>Medical (Not Dental) Necessity Applies. 80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

**EMERGENCY TREATMENT**

<table>
<thead>
<tr>
<th><strong>Description</strong></th>
<th><strong>Benefits</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Emergency Room Care for a Sudden Serious Illness or Injury that Requires Hospital Services</td>
<td>For emergency conditions only. No coverage for non-emergency use of ER. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Medical Transport Services Other Than Ground</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
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</table>

**HOME HEALTH CARE**

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<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Services</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Medical Social Services</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Nutritional Guidance</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
</tbody>
</table>
### Therapy - Occupational

Notification required.
80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required. **Maximum: 20 visit limit per person per plan year.** Limit applies to all occupational therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

### Therapy - Physical

Notification required.
80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required. **Maximum: 30 visit limit per person per plan year.** Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

### Therapy - Speech

Notification required.
80% of covered charges after annual deductible. Applies only if care in a hospital or skilled nursing facility would otherwise be required. **Maximum: 20 visit limit per person per plan year.** Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.
### HOSPICE CARE

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<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Laboratory Tests</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Medical Services</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Skilled Nursing Care</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
<tr>
<td>Therapy - Inhalation</td>
<td><strong>Notification required.</strong> 80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.</td>
</tr>
</tbody>
</table>
| Therapy - Physical                          | Notification required.  
80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.  

Maximum: 30 visit limit per person per plan year. Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization. |
| Therapy - Speech                           | Notification required.  
80% of covered charges after annual deductible. Coverage provided for a terminally ill patient if life expectancy is six months or less and care in a hospital or skilled nursing facility would otherwise be required.  

Maximum: 20 visit limit per person per plan year. Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization. |
### HOSPITALIZATION - INPATIENT

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<td>Anesthesia Supply and Administration</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Bandages and Dressings</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Blood Transfusions</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Coronary Care</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Diagnostic Tests</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Electrocardiograms (EKGs)</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Electroencephalograms (EEGs)</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Extended Care Facility</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Hospital Care - Inpatient Supplies</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Hospital Care - Inpatient Surgery - Physician Services</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------------</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Laboratory Exams</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Operating Room Services</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Oxygen Supply and Administration</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Physician Visit</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Plasma Transfusion</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Pre-Admission Tests</td>
<td>Notification required. 80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>
### Prescription Medications Administered During Hospitalization

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<th>Description</th>
<th>Benefits</th>
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</thead>
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<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible. Retail prescription coverage for other covered prescription medications.</td>
</tr>
</tbody>
</table>

### Recovery Room Services

<table>
<thead>
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<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

### Semi-Private Room and Board

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

### Therapy - Physical

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

### Therapy - Radiation

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

### X-Rays

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification required.</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

### ORGAN TRANSPLANTS

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Bone Marrow Search and Procurement

100% of covered charges after annual deductible if Organ Transplant network is used. 80% of covered charges after annual deductible if Organ Transplant network is not used and there is no out-of-pocket maximum.

**Maximum:** Reasonable costs of searching for a bone marrow donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

### Non-medical Expenses - Air or Ground Transportation From the Patient's or Family Member's Place of Primary Residence to the Hospital Where the Transplant is Performed and Back

80% of covered charges after annual deductible. For covered person receiving the transplant and for one member of the covered person's immediate family (two members if the patient is age 17 or under), during the covered person's confinement in the hospital.

**Maximum:**
Non-medical air or ground transport expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical air or ground transport expenses for covered person's immediate family member(s) will only be paid if immediate family member(s) reside more than 100 miles from transplant facility. Up to $10,000 in payments per transplant for all non-medical expenses (for covered person and all family members).
| Non-medical Expenses - Lodging | 80% of covered charges after annual deductible. For covered person receiving the transplant and for one member of the covered person's immediate family (two members if the patient is age 17 or under), during the covered person's confinement in the hospital.  

**Maximum:**
Non-medical expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical expenses for covered person's immediate family member(s) will only be paid if immediate family member(s) reside more than 100 miles from transplant facility. Up to $75 lodging expense per day incurred by a covered person receiving the transplant (when not hospitalized) and up to $75 lodging expense per day incurred by a covered person's immediate family member(s). Lodging coverage for immediate family is limited to one room. Up to $10,000 in payments per transplant for all Non-medical expenses (for covered person and all family members). |
| Organ Search and Procurement | 100% of covered charges after annual deductible if Organ Transplant network is used. 80% of covered charges after annual deductible if organ transplant network is not used and there is no out-of-pocket maximum. |
Organ Transplants | Pre-transplant notification required.
--- | ---
| 100% of covered charges after annual deductible if Organ Transplant network is used. 80% of covered charges after annual deductible if Organ Transplant network is not used and there is no out-of-pocket maximum.
| Includes:
  - Bone Marrow - Allogenic for certain diagnosis,
  - Bone Marrow - Autologous for certain diagnosis,
  - Heart,
  - Heart-Lung,
  - Kidney,
  - Liver,
  - Lung,
  - Multivisceral,
  - Pancreas,
  - Pancreas-Kidney,
  - Small Bowel.
| Any transplant not listed above required by state or federal law.

<p>| OTHER SERVICES |
|---|---|
| <strong>Description</strong> | <strong>Benefits</strong> |
| Acupuncture | 80% of covered charges after annual deductible. Must be performed by licensed acupuncturist or MD. |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Diapers Prescribed to Treat Medical Condition</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Assisting Surgeon's Fees / Physician's Assistant / Nurse Practitioner</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Chiropractors</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum: 20 visits per person per plan year.</strong></td>
</tr>
<tr>
<td>Circumcision - Adult - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Cochlear Implants - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Diabetes Education</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Disposable Medical Supplies Prescribed to Treat Medical Illness or</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Injury</td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td><strong>Notification required for equipment in excess of $1,200.</strong></td>
</tr>
<tr>
<td></td>
<td>80% of covered charges after annual deductible. Includes repairs and replacements.</td>
</tr>
<tr>
<td>Durable Medical Equipment Batteries</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Foot Orthotic</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td></td>
<td>Maximum: One pair per person per plan year for shoes worn most often.</td>
</tr>
<tr>
<td>Hospital Care - Outpatient - Non-Surgery</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Hospital Care - Outpatient - Supplies</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Hospital Care - Outpatient - Surgery</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Kidney Dialysis Facility</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Nursing Care</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td></td>
<td>Includes registered/graduate nurses (and in some cases, Licensed Practical Nurses). Does not include hospital inpatient nurses.</td>
</tr>
<tr>
<td>Nutritional Supplements Other Than Infant Formula</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td></td>
<td>Supplements must be the only source of nutrition.</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Pain Control Clinic</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Post - Surgical Care</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Service Description</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Private Duty Nursing Care</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Prosthetic Devices / Appliances</td>
<td>Notification required for equipment in excess of $1,200.</td>
</tr>
<tr>
<td></td>
<td>80% of covered charges after annual deductible. Includes repairs and replacements.</td>
</tr>
<tr>
<td>Rehabilitation Facility (Non-Behavioral Health)</td>
<td>Notification required.</td>
</tr>
<tr>
<td></td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Sleep Disorder Treatment</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgeons</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgery - Breast Reduction Surgery - Physician Services</td>
<td>Notification required.</td>
</tr>
<tr>
<td></td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgery - Cosmetic Surgery for Certain Birth Defects when Medically Necessary to</td>
<td>Notification required.</td>
</tr>
<tr>
<td>Improve Function - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgery - Nasal Surgery to Correct Function - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgery - Oral Surgery by Physician or Oral Surgeon to Treat Jaw Fracture or</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Dislocation - Physician Services</td>
<td></td>
</tr>
<tr>
<td>Surgery - Podiatry - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>
### Surgery - Reconstructive Surgery
Related to a Surgical Procedure, Illness or Accident Which Would be Covered Under This Plan - Physician Services

- Notification required for Blepharoplasty (upper lid), Ligation, Vein Stripping, and Sclerotherapy.
- 80% of covered charges after annual deductible.

### Surgery - Sleep Apnea Surgery - Physician Services

- 80% of covered charges after annual deductible.

### Wigs for Hair Loss Due to Chemotherapy or Accident

- 80% of covered charges after annual deductible.
- **Maximum**: $250 per person per lifetime for one wig only.

### PREVENTIVE CARE

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| Exams - Routine Eye Exams | 50% of covered charges. Deductible does not apply.  
**Maximum**: $100 charge or $50 payment, one exam per person per plan year. |
| Exams - Routine Gynecological Exams for All Female Members | 80% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.  
**Maximum**: One exam per person per plan year. |
<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exams - Routine Physical Exams</strong></td>
<td>50% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum:</strong> $250 charge or $125 payment, one exam per person per plan year.</td>
</tr>
<tr>
<td><strong>Exams - Routine Well Baby Exams</strong></td>
<td>80% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum:</strong> For children up to age 1, as often as determined appropriate by physician.</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>80% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td><strong>Mammography Screens for All Female Members</strong></td>
<td>100% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td></td>
<td><strong>Maximum:</strong> 1 screen per physician recommendation for females age 35-39, one screen every year per physician recommendation for females age 40 and over.</td>
</tr>
<tr>
<td><strong>Pap Smear</strong></td>
<td>80% of covered charges. Charges are not applied toward preventive care routine physical exam maximum. Deductible does not apply.</td>
</tr>
<tr>
<td>Service Description</td>
<td>Coverage Details</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Birthing Center/Hospital Delivery</td>
<td>Notification is based on network carrier criteria. 80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>D&amp;C/Abortion - Therapeutic Outpatient Surgery</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Dependent Child Pregnancy</td>
<td>80% of other covered charges after annual deductible. Includes Pre-natal, Post-natal and Delivery Care. (Newborn of dependent not covered.)</td>
</tr>
<tr>
<td>Midwife Delivery in Facility</td>
<td>Notification is based on network carrier criteria. 80% of covered charges after annual deductible. No coverage for at-home deliveries.</td>
</tr>
<tr>
<td>Newborn Circumcision - Physician Services</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Newborn Hospitalization</td>
<td>Notification required. 80% of covered charges after annual deductible. For confinement past mother's stay and new admissions to hospital.</td>
</tr>
<tr>
<td>Pre-Natal and Post-Natal Care</td>
<td>80% of covered charges after annual deductible. As often as determined appropriate by doctor.</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>
### TREATMENT OF ILLNESS OR INJURY

<table>
<thead>
<tr>
<th>Description</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Care</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>80% of covered charges after annual deductible. Includes MRI / MRA / CT / PET / SPEC scans.</td>
</tr>
<tr>
<td>Laboratory Fees</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>Surgical Opinion - Second</td>
<td>100% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td>Surgical Opinion - Third</td>
<td>100% of covered charges. Deductible does not apply.</td>
</tr>
<tr>
<td>Therapy - Radiation Therapy / Chemotherapy</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
<tr>
<td>X-Rays</td>
<td>80% of covered charges after annual deductible.</td>
</tr>
</tbody>
</table>

#### Deductibles

The Plan requires that you meet a deductible before benefits begin. To protect you from large medical bills, the Plan limits your *out-of-pocket* covered medical expenses.

The Plan also has annual dollar and frequency maximums on certain services.

For all covered services and supplies, you pay a *coinsurance* rate.
The deductible is the amount you pay each calendar year for covered expenses before the Plan pays medical benefits. There is no deductible for prescription medications.

The medical deductible for a calendar year is:

- $100 for an individual; and
- $200 for a family.

If you have family coverage, your family will meet the family deductible when all covered family members have combined eligible expenses of $200 for the calendar year. However,

- no one individual can contribute more than his or her individual deductible toward the family deductible;
- until the family deductible is satisfied, claims for each family member are still subject to his or her individual deductible; and
- if two or more covered family members are hurt in the same accident, only one $100 deductible must be satisfied for all covered charges related to the accident.

Once the family deductible has been satisfied, the deductible for all family members is considered satisfied for the remainder of the calendar year. Future covered expenses for all family members during that year will be paid according to the Plan's benefit schedule.

You should submit claims before you have met your deductible.

**Note:**

- The annual deductible does not apply for routine and preventive care, such as physical exams, immunizations and gynecological exams.
- Your medical deductible does count toward your medical out-of-pocket maximum amount.
Emergency and Urgent Care Benefits

Whenever you need emergency room or urgent care treatment (if available in your area) in a sudden and serious situation, benefits will be paid at 80% of covered charges, subject to the deductible.

Hospitalization

The Plan covers medically necessary inpatient and outpatient hospital services, including:

- hospital room and board for a semi-private room;
- intensive care and other special unit charges;
- operating and other treatment room charges;
- anesthetics and their administration;
- x-ray and lab services;
- medications and supplies; and
- other hospital services and supplies required for medical or surgical care and treatment.

Generally, after all deductible requirements are met, the Plan covers 80% of the reasonable and customary charges for covered expenses until you reach your out-of-pocket maximum.

After you meet your annual out-of-pocket maximum, the Plan pays 100% of the reasonable and customary charges.

Hospital admissions require notification/authorization in order for you to receive full benefits.

The procedure you must follow to provide notification varies with the type of admission. Failure to provide notification/authorization may result in a substantial benefit reduction, therefore it is strongly recommended that you follow the necessary notification/authorization procedure for each hospitalization, whether it be a scheduled or emergency admission.

For additional information, contact UnitedHealthcare.
Limitations and Exclusions

The plan does not cover certain types of treatment, services and supplies. In some cases, covered treatment may have limitations, such as annual benefit maximums or frequency limits for certain services or supplies.

Health care benefits coverage in this Plan is not provided to those who reside in a foreign country. Emergency coverage is available for covered members who experience illness or injury while on temporary travel to foreign countries.

Pre-Existing Conditions

The Plan has no limits on treatment of pre-existing conditions.

Reasonable and Customary Charges

If your provider charges you more than the reasonable and customary charge and there is no payment agreement between the provider and the Plan, you are responsible for paying:

- the difference between the reasonable and customary charge and the actual charge; plus
- any amounts which are normally your responsibility under the Plan, such as coinsurance.

As an example of what happens when the fee for a medical service exceeds the reasonable and customary, assume:

- medical charges are $650 but the reasonable and customary charge is $600;
- you have already met your deductible, but have not yet reached your out-of-pocket maximum; and
- the Plan pays 80%.

The Plan would pay a benefit of $480 (80% times $600). You are responsible for $170, calculated as follows:

- 20% of $600 equals $120, which is your coinsurance amount; plus
• $50, which is the difference between your doctor's charge of $650 and the reasonable and customary charge of $600.

Any amount which exceeds the reasonable and customary charge will not be applied toward your out-of-pocket maximum.

Note:

• If you are not Medicare eligible, UnitedHealthcare's Preferred Provider Organization (PPO) plan offers services at rates that generally do not exceed reasonable and customary charges. Voluntarily utilizing the services of PPO providers can provide savings in your out-of-pocket expenses. You can access the providers if you live near a local network area or are traveling.
• If you are eligible for Medicare, the "Medicare approved" charges are considered to be reasonable and customary.

To determine if a fee is within the Plan's limits for a reasonable and customary charge, contact UnitedHealthcare.

Calling UnitedHealthcare to determine if a fee is within reasonable and customary limits does not eliminate your need to follow the Plan's notification/authorization requirements. Failure to provide notification/authorization will result in benefit reductions.

You can locate PPO providers by:

• calling UHC customer service
• visiting www.myuhc.com and selecting the PPO product

Services, Treatments and Supplies Not Covered

The Plan does not cover:

• admission or continued hospital or skilled nursing facility stay for care not medically required on an inpatient basis;
• ambulance service - transportation provided by other than a licensed professional ambulance service;
aquatic therapy, unless provided under the Treatment of Injury/Illness section of this Plan;
art therapy, training, supplies or treatments and any related diagnostic testing;
benefits - any item, service, supply or care not specifically listed as a covered benefit under this Plan;
biofeedback therapy, training, supplies or treatments and any related diagnostic testing;
charges for completion of claim forms;
charges for documentation of medical history;
charges for failure to keep a scheduled visit;
charges for holiday, overtime or weekend rates;
charges for participation in legal proceedings;
charges for physician or hospital standby services;
charges for reserving or holding a room or bed that is not being occupied by the member;
charges not covered because you did not follow notification/authorization procedures;
chelation therapy except in the treatment of heavy metal poisoning;
childbirth classes;
claims filed after claims filing deadline as described in the Procedures > Claims section of this Plan;
claims submitted after the claims filing deadline as described in the Procedures > Claims section of this Plan;
communication augmentation devices and related instruction or therapy;
convenience items - services and supplies for patient convenience such as telephone, television, guest trays and personal hygiene items unless required for a medical condition;
cosmetic or reconstructive surgery, treatments, and supplies except to restore function of any body area altered by disease, trauma, congenital/developmental anomalies or previous therapeutic processes which would normally be covered by the Plan;
court-ordered - any treatment or therapy which is court ordered, ordered as a condition of parole, probation, or custody or visitation evaluation;
coverage date - services or supplies provided before the effective date of coverage or after the termination of coverage;
coverage limits - continued coverage of services when specified limits of coverage have been achieved;

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2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

- dance therapy, training, supplies or treatments and any related diagnostic testing;
- dental - any procedure (e.g., vestibuloplasty) intended to prepare the mouth for dentures or for the more comfortable use of dentures;
- dental - dental implants;
- dental - dentures, appliances, or supplies used in such treatments, unless provided for elsewhere in the Plan;
- dental care, services, supplies or treatment and oral surgery (by physicians or dentists) including dental surgery or other dental procedures. Exceptions: oral surgery to correct congenital defects that prohibit normal function for a covered child; the treatment of temporomandibular joint syndrome (TMJ) or myofacial pain (coverage is limited to removable appliances for TMJ repositioning, related diagnostic services and necessary surgical intervention for correction of TMJ); treatment of traumatic accidental injury, other than one associated with chewing;
- diagnostic services performed in the absence of definite symptoms of an illness;
- duplicate testing not deemed necessary for diagnosis or treatment;
- durable medical equipment items for comfort or convenience;
- eating disorders - services for inpatient treatment of bulimia, anorexia or other eating disorders that consist primarily of behavior modifications, diet and weight monitoring and educational services. This exclusion applies unless prior approval has been obtained for treatment of conditions that are life threatening;
- educational therapy, training, supplies or treatments and any related diagnostic testing;
- educational/developmental services or supplies, including those supplies deemed educational/developmental;
- elastic stockings and bandages including trusses, lumbar braces, garter belts and similar items that can be purchased without a prescription;
- environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers or vacuum devices;
- experimental, investigational or unproven care, treatment, medications which are experimental or investigational in terms of generally accepted medical standards;

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2006 Summary Plan Description
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- fitness - general fitness programs, exercise programs, exercise equipment and health club memberships;
- foot care - services for routine foot care or the treatment of flat feet, corns, bunions, calluses, toenails, fallen arches, weak feet or a chronic foot strain, unless the treatment is an approved surgical or medical procedure;
- foreign country medical services - non-emergency services rendered outside of the United States or U.S. sovereign territories. Coverage is provided for covered members who experience emergency illness or injury while on temporary travel to foreign countries;
- gender modification - surgical or medical treatment to identify or modify the gender of an individual or directly related to gender modification or identification;
- genetic counseling and genetic testing and/or care that is directly related to genetic testing that has not been approved by the plan;
- government plans - services, supplies, treatments, or medications eligible for submission for coverage by Workers' Compensation, Medicare, or similar government plans, whether or not coverage was elected or a claim for coverage was submitted;
- habilitative services;
- hair transplants, hair weaving, hair pieces, wigs, wig maintenance, cranial prosthesis, medications or other services, related to or for inadequate hair growth or loss of hair unless otherwise stated by the Plan;
- hearing aids or examination for fitting;
- hearing tests except when medically indicated to rule out suspected hearing disorder;
- holistic or homeopathic - treatment, services or supplies for holistic or homeopathic medication or other programs that are not accepted medical practices, as determined by the Plan;
- home health-care services which are not medically necessary or of a non-skilled level of care;
- home services - food, housing, homemaker services, sitters, home-delivered meals;
- hospitalization or confinement in a health facility primarily for rest, custodial, maintenance or domiciliary care; or to control or change environment, such as confinement in an eating disorder unit;
- hospitalization primarily for X-ray, laboratory or any other diagnostic studies or medical observation;

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• in-home birth - services, supplies or care provided during in-home births. Exception - emergency response care;
• infant formula;
• infertility - services or supplies in connection with any procedure intended to facilitate a pregnancy;
• inpatient - exams or tests done as inpatient for convenience when such care could be provided in an outpatient facility;
• inpatient hospitalization and related services or care rendered primarily for diagnostic studies or observation;
• inpatient or outpatient care, when the participant is medically stable and does not require skilled nursing care or the constant availability of a physician, or the treatment is primarily for congenital or neurological learning disorder, maintaining the current level of health (habilitative), communication training, educational training, vocational training, or the patient has no restorative potential;
• legal - medications or care received in violation of the law;
• maintenance or custodial care, rest cures or travel expenses even if recommended for health reasons by a physician. Transportation to another area for medical care is also excluded except when medically necessary and authorized for you to be moved by professional ambulance service from one hospital to another;
• maintenance or custodial care; care which is provided to maintain an individual at the current level of functioning or primarily to assist with activities of daily living;
• male gynecomastia - cost associated with male gynecomastia;
• massage therapy, unless provided under the Physical Therapy provision of this Plan;
• maxillary or mandibular implants unless for restoration of function following trauma or dysfunction due to medical disorder;
• medical necessity - care, supplies or equipment not medically necessary for the treatment of injury or illness including, but not limited to employment, camp, sports, insurance or aviation physicals and other third party exams; Care must be consistent with the symptom or treatment of the condition; meet the standard of practice; not be solely for anyone's convenience; be the most appropriate supply or level of care safely provided. For inpatient care, it means care cannot be safely provided as an outpatient;
medications - legend - prescription medications prescribed by a licensed physician and dispensed by a physician or pharmacist as a legend medication (prescription benefits may apply);
medications - prescription medications normally covered under a prescription medication program (whether or not the medical benefits carrier provides your prescription medication coverage);
medications other than those administered while in the hospital or physician’s office, unless benefits are provided elsewhere in this Plan;
medications which do not require a prescription;
military service or act of war - treatment of illness and injury caused by any military service or act of war, declared or undeclared between governments or government-like entities and not simply by a group prone to violence;
modifications to your home or property, such as but not limited to, escalator(s), elevators, saunas, steam baths, pools, hot tubs, whirlpools, tanning equipment, wheelchair lifts, stair lifts or ramps;
motor vehicle purchase, rental or conversion to accommodate a disability;
multiple Plan provisions - covered expenses (services, supplies, equipment, facilities, etc.) will be paid under only one provision of the Plan;
music therapy, training, supplies or treatments, and any related diagnostic testing;
non-covered expenses - expenses for services, treatments, supplies, or medications that have been determined as non-covered through notification/authorization, concurrent or retrospective review, and/or appeal review;
nutritional supplements except in situations where supplements are the only source of nutrition for an individual, the condition was caused by medical disease or injury, and authorization is obtained;
obesity - treatment for obesity;
organ transplants - costs for or in connection with a transplant when the patient or provider has not followed notification/authorization requirements or the patient or provider has been notified by the plan that the organ transplant will not be covered by the plan. Includes all services, treatments or supplies related to pre-transplant evaluation, the transplant procedure, follow-up care, and pre and post transplant prescription medications;
organ transplants - government-sponsored services, such as Medicare's program for kidney transplants, for which benefits would have been paid if they had been applied for on a timely basis;
organ transplants - pre and post-transplant prescription medications - covered under the prescription medication benefits;
organ transplants - services related to donation of organs or tissues if the recipient of the donation has donor expense coverage;
organ transplants - surgical or medical care related to animal organ transplants, animal tissue transplants, artificial organ transplants or mechanical organ transplants;
organ transplants - transplants of organs, tissues or bone marrow other than those approved prior to transplantation;
organ transplants - travel time and related expenses of an organ donor;
other Company plans - expenses which are covered by another Plan to which the Company contributes;
payment - care for which you have no legal obligation to pay;
payment - charges for services or supplies when another Plan, person or third party has the obligation to provide funds for payment;
payment - excessive Plan payments due to a provider waiving a portion of his/her typical charges. If a provider routinely waives (does not require you to pay) a co-payment, deductible, or coinsurance, the claims administrator will calculate the eligible charges by reducing the fee or charge by the amount waived;
payment - services or supplies for which funds which could be used for payment of medical expenses were received in a legal action or settlement;
payment - services or supplies for which you would not be obligated to pay in the absence of this Plan or which are provided to you, or your dependent, at no cost;
payment - services paid under Medicare, any local, state, or federal government, or Worker's Compensation or which would have been paid if the member had applied for benefits;
penile implant devices and surgery, and any related services, except for any resulting complications and medically necessary services as provided under reconstructive surgery benefits;
physician care - any services for any period during which the participant is not under the continuing care of a physician;
physician licensure - services or supplies that are not performed by or prescribed by a physician licensed to practice medicine, except where otherwise specified;
- private duty care - services or supplies in connection with private duty care, except when licensed nursing care is authorized as medically necessary and the care is provided under the Home Health Care, Home Hospice Care, Facility Hospice Care and Organ Transplants benefits;
- providers - services of a provider who ordinarily resides in the patient's home or is a member of the family of either the patient or the patient's spouse;
- reading therapy, training, supplies or treatments and any related diagnostic testing;
- reasonable, usual and customary charges - expenses in excess of the reasonable, usual and customary charges (as determined by the Claims Administrator);
- recreational therapy, training, supplies or treatments, and any related diagnostic testing;
- residency - services, treatments or supplies for employees or retirees and dependents residing outside of the United States or U.S. sovereign territories;
- routine exams and tests except as provided for under the Preventive Care section of this Plan;
- self-care or self-help training, supplies or treatments, and any related diagnostic testing;
- sex therapy;
- sexual dysfunction - treatment for impotency, loss of libido, or other sexual dysfunctions or inadequacies;
- smoking deterrents or other services or supplies used to treat dependency on nicotine;
- sterilization reversal - services or supplies related to or for reversal of previous sterilization procedures;
- telemedicine;
- vision - purchase or fitting of eye glasses or contact lenses, unless provided elsewhere in the Plan;
- vision - radial keratotomy or other surgery, services or supplies for the correction of visual defects or for vision improvements;
- vision - vision therapy or orthoptics (eye exercises), unless provided elsewhere in the Plan;
- vocational or industrial rehabilitation;
- vocational therapy, training, supplies or treatments or any related diagnostic testing;
• weight control programs, therapy, training, supplies or treatments and any related diagnostic testing;
• weight reduction or dietary control - services or supplies used to assist in weight reduction or dietary control, including gastric bypass procedures;
• work-connected injuries or diseases – services, supplies, treatments or medications for or in association with injuries or diseases which have been medically determined as occupationally acquired.

Maximums

An "out-of-pocket maximum" limits the amount of money you must pay each year for your share of covered expenses. Only the reasonable and customary portion of charges go toward the out-of-pocket maximum and once the maximum is met, only the reasonable and customary portion of charges are considered for payment by the Plan. Expenses from services or supplies that are paid at 50% coverage by the Plan, such as outpatient behavioral health treatment, are not included when determining the amount you have paid toward the out-of-pocket maximum.

Once you and/or your dependents reach the maximum, the Plan will pay 100% of most of the covered expenses for the rest of the year.

In addition, any expenses the Plan would not normally pay will continue to be your responsibility even after the out-of-pocket maximum has been reached.

The following maximums (listed order as they appear in your Coverage Information chart) apply to this Plan:

COVERAGE INFORMATION OVERVIEW

Annual Out-of-Pocket Maximum

• Maximum:
  $1,575/Person or Family
  The following apply to the out-of-pocket maximum:
  *co-insurance (except behavioral health, out-of-Organ Transplant Network-organ transplants and retail/home delivery prescription medications),
  *deductibles.
Lifetime Maximum Benefit

- Maximum:
  Unlimited. Benefit-specific limits may apply.

Prescription Medications

- Maximum: 34-days supply for Retail. 120 days supply for Home Delivery.
  Maximum: $1,500 out-of-pocket maximum per person or family per plan year.

Prescription Medications - Where Over-The-Counter (OTC) Equivalents Are Available (Medications that can be obtained without a prescription and are considered by pharmacists and other specialists to be equivalent to certain prescription medications)

- Maximum: 34-days supply for Retail. 120 days supply for Home Delivery.

Therapy - Occupational

- Maximum: 20 visit limit per person per plan year. Limit applies to all occupational therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

Therapy - Physical

- Maximum: 30 visit limit per person per plan year. Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

Therapy - Speech

- Maximum: 20 visit limit per person per plan year. Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

BEHAVIORAL HEALTH TREATMENT

Outpatient Services
HOME HEALTH CARE

Therapy - Occupational

- Maximum: 20 visit limit per person per plan year. Limit applies to all occupational therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

Therapy - Physical

- Maximum: 30 visit limit per person per plan year. Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

Therapy - Speech

- Maximum: 20 visit limit per person per plan year. Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

HOSPICE CARE

Therapy - Physical

- Maximum: 30 visit limit per person per plan year. Limit applies to all physical therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.

Therapy - Speech

- Maximum: 20 visit limit per person per plan year. Limit applies to all speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.
Bone Marrow Search and Procurement

- Maximum: Reasonable costs of searching for a bone marrow donor may be limited to the immediate family members and the National Bone Marrow Donor Program.

Non-medical Expenses - Air or Ground Transportation From the Patient's or Family Member's Place of Primary Residence to the Hospital Where the Transplant is Performed and Back

- Maximum: Non-medical air or ground transport expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical air or ground transport expenses for covered person's immediate family member(s) will only be paid if immediate family member(s) reside more than 100 miles from transplant facility. Up to $10,000 in payments per transplant for all non-medical expenses (for covered person and all family members).

Non-medical Expenses - Lodging

- Maximum: Non-medical expenses for covered person will only be paid if covered person resides more than 100 miles from transplant facility. Non-medical expenses for covered person's immediate family member(s) will only be paid if immediate family member(s) reside more than 100 miles from transplant facility. Up to $75 lodging expense per day incurred by a covered person receiving the transplant (when not hospitalized) and up to $75 lodging expense per day incurred by a covered person's immediate family member(s). Lodging coverage for immediate family is limited to one room. Up to $10,000 in payments per transplant for all Non-medical expenses (for covered person and all family members).

OTHER SERVICES

Chiropractors

- Maximum: 20 visits per person per plan year.
Foot Orthotic

- Maximum: One pair per person per plan year for shoes worn most often.

Wigs for Hair Loss Due to Chemotherapy or Accident

- Maximum: $250 per person per lifetime for one wig only.

PREVENTIVE CARE

Exams - Routine Eye Exams

- Maximum: $100 charge or $50 payment, one exam per person per plan year.

Exams - Routine Gynecological Exams for All Female Members

- Maximum: One exam per person per plan year.

Exams - Routine Physical Exams

- Maximum: $250 charge or $125 payment, one exam per person per plan year.

Exams - Routine Well Baby Exams

- Maximum: For children up to age 1, as often as determined appropriate by physician.

Mammography Screens for All Female Members

- Maximum: 1 screen per physician recommendation for females age 35-39, one screen every year per physician recommendation for females age 40 and over.

Contact UnitedHealthcare for information on limitations which may exist for other types of treatments and to find out how much you have accumulated toward your out-of-pocket maximum.

The Women's Health and Cancer Rights Act of 1998 is United States federal legislation that sets coverage requirements for reconstructive breast surgery and related surgical procedures, as well as prostheses. The P&G health care plans comply with this legislation through coverage of the following:

- coverage for reconstruction of the breast on which a mastectomy has been performed;
- coverage for surgery and reconstruction of the other breast to produce a symmetrical appearance;
- coverage for prostheses and physical complications through all stages of mastectomy, including lymphedema; and
- coverage in a manner that is determined in consultation with the attending physician and patient.

All terms of the plan concerning employee cost share (co-pays, deductibles, coinsurance, etc.) and notification/authorization apply to this coverage.
Coordination of Benefits

If you or your dependents are covered by more than one Plan, the payment of benefits is coordinated between the plans. This is called Coordination of Benefits (COB). Specific Plan rules define how benefits are paid and where claims are submitted first.

Prescription benefits may also be coordinated.

The first payer is called the primary plan or carrier, and the second payer is called the secondary plan or carrier.

Procter & Gamble’s Plan will coordinate with benefits that you, or any other covered persons, receive from:

- a government program or programs provided or required by law, including mandatory no-fault automobile insurance (Note: Dental Plan does not coordinate benefits with Medicare or Medicaid);
- law suits;
- any other group insurance plan or coverage for a group of individuals, including coverage from a school above the high school level.

If benefits are paid from one or more of these sources, the total benefits received from Procter & Gamble may not exceed the actual charges. The primary plan will pay benefits first for the covered charges you incur. The secondary plan will pay benefits for any remaining eligible charges. Benefits paid will never exceed what the P&G Plan would have paid had it been the only coverage.

If Procter & Gamble’s Plan is secondary, benefits may be reduced so that the total benefits paid to you from all sources do not exceed 100% of your eligible and covered expenses. You may be asked to provide any information needed to administer this provision.

Note: Even if your Procter & Gamble Plan is the secondary Plan, you must follow any required notification/authorization procedures to receive full benefits from the P&G Plan.
Claims may be paid differently if the other plan is an HMO, or if your primary plan pays reduced benefits because you did not comply with provisions of that plan.

If the HMO is the primary plan and your P&G Plan is the secondary plan, the P&G Plan will not provide secondary coverage for services rendered outside the HMO (and therefore not covered by the primary plan).

If you receive reduced benefits because you do not comply with provisions (i.e., notification/authorization, etc) required by the other plan (not an HMO), the amount of that reduction will not be considered an allowable expense by the P&G Plan.

If an HMO is the secondary plan, how it coordinates benefits with the P&G Plan is specific to the HMO. Check with the HMO to determine how it handles nonduplication of benefits.

For additional information, contact UnitedHealthcare.

Coordination With Medicare

Individuals become eligible for Medicare when they reach age 65. Medicare has two parts: hospital insurance (Part A) and medical insurance (Part B). Medicare is the federal government's health insurance program for:

- people age 65 or older;
- some people with disabilities under age 65; and
- people with end-stage renal disease (permanent kidney failure requiring dialysis or a transplant).

There are different rules for enrolling for each part as follows:

- **Medicare Part A**: You do not have to enroll for Part A if you are receiving Social Security payments when you reach age 65 or if you have qualified for Social Security disability payments for 24 months. In either case, Part A coverage is automatic and there is generally no cost to you.
- **Medicare Part B**: You must enroll separately for Part B. It is important to enroll promptly. You can sign up for Part B anytime during a 7-month period that begins 3 months before you turn 65. However, enrolling during or after the month you turn 65 will delay your eligibility for Medicare. It costs 10% more for
each full 12 months that you did not participate when you were eligible to do so. You will have to pay this 10% for the rest of your life. **You should contact your Social Security Office 3 months prior to reaching age 65.**
Early Eligibility for Medicare

You or one of your covered dependents may become eligible for Early Medicare because of a disability prior to reaching age 65. You become eligible two years after you are awarded Social Security Disability benefits. Medicare is the primary coverage for anyone awarded Early Medicare. Anyone on Early Medicare pays a reduced monthly premium rate so you should notify the Employee Service Center.

Although Medicare Parts A and B cover most of your medical expenses, there are some important features of the P&G Retiree Health Care Plan that provide you with valuable coverage:

- prescription medications are covered;
- Medicare has a deductible for hospital stays. These expenses are paid by P&G plans (after any deductibles that might apply are satisfied);
- P&G plans cover other services not covered by Medicare, such as the first three pints of blood for transfusions, chiropractic services and others;
- P&G plans provide benefits when doctors do not accept Medicare fees as payment in full; and
- P&G plans pay benefits for emergency expenses incurred while traveling outside the United States. These expenses are generally not covered by Medicare.

The P&G Retiree Health Care Plan is integrated with the health care coverage provided by Medicare so that it provides the same level of coverage that you would have under the plan without Medicare. In other words, if the Medicare benefit payment is equal to the coverage that the plan would pay without Medicare, there is no additional payment by the P&G Retiree Health Care Plan.

In order to integrate Medicare and the P&G Retiree Health Care Plan, UnitedHealthcare calculates the amount that would have been provided to you without Medicare. From this amount they subtract the expenses covered by Medicare Parts A and B. You receive from UnitedHealthcare what the P&G Retiree Health Care Plan would have paid minus the Medicare benefits. In other words, the combined Plans provide you with the same level of coverage you would have without Medicare.
If you are eligible for Medicare Part B, United HealthCare will pay your claims as if Medicare paid 80% of the charges even if you are not enrolled in Medicare Part B. This means that you may be responsible for all of the charges if you do not enroll for Medicare Part B when you are eligible.

For the purposes of this example, assume:

- you have a medical claim for covered expenses of $100;
- this service falls under the UHC Base Plan; and
- the Plan will pay 80%.

You submit the claim:

- first to Medicare, as the primary plan, and it pays 80% or $80; then
- to the UHC Base Plan, which considers what it would have paid if it had been primary (in this case 80% or $80) and subtracts what the other plan paid ($80 - $80 = $0);
- the retiree pays $20 co-insurance.

The amount paid by the primary plan equals what the Procter & Gamble Plan would have paid if it had been primary; therefore no additional benefits will be paid.

If, in this example, you have reached your out-of-pocket maximum, the Plan would pay 100%. The UHC Base Plan would have paid the remaining $20 balance.

**More Examples of Medicare As Primary and UnitedHealthcare As Secondary**

**After You Have Met The Deductible**
If your doctor accepts assignment.

<table>
<thead>
<tr>
<th>Expense</th>
<th>Medicare Allows</th>
<th>Medicare Pays</th>
<th>P&amp;G Plan Pays</th>
<th>Medicare Plus The P&amp;G Plan</th>
<th>You Owe</th>
</tr>
</thead>
<tbody>
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<td>$120</td>
<td>$100</td>
<td>$80</td>
<td>$0</td>
<td>$80</td>
<td>$20</td>
</tr>
</tbody>
</table>

If your doctor does **not** accept assignment:
### After You Have Met Your Out-of-Pocket Maximum

**If your doctor accepts assignment:**

<table>
<thead>
<tr>
<th>Expense</th>
<th>Medicare Allows</th>
<th>Medicare Pays</th>
<th>P&amp;G Plan Pays</th>
<th>You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$120</td>
<td>$100</td>
<td>$80</td>
<td>$16</td>
<td>$96</td>
</tr>
</tbody>
</table>

**If your doctor does **not** accept assignment:**

<table>
<thead>
<tr>
<th>Expense</th>
<th>Medicare Allows</th>
<th>Medicare Pays</th>
<th>P&amp;G Plan Pays</th>
<th>You Owe</th>
</tr>
</thead>
<tbody>
<tr>
<td>$120</td>
<td>$100</td>
<td>$80</td>
<td>$40</td>
<td>$0</td>
</tr>
</tbody>
</table>

If you receive care from a doctor who does not accept Medicare, you may pay more and you will need to file your own claim with Medicare. Medicare will then reimburse you the amount that it pays to doctors who contract with Medicare. Once you receive your Medicare Explanation of Benefits, then you can file your claim with UnitedHealthcare.

If you receive care that is covered by the Retiree Health Care Plan, but not by Medicare, you will be reimbursed from the Plan based on the full *reasonable and customary* charge.

### Medicare Crossover

UnitedHealthcare has a Medicare crossover plan whereby claims automatically are sent from Medicare to UnitedHealthcare for processing. You usually do not have to file a claim or send information for many of the services covered under Medicare. Medicare Crossover does not yet apply to Medicare Part A claims or to prescription...
medication claims. Claims for these types of expenses should continue to be filed as they have been filed in the past.

There is no cost for Medicare Crossover and it has no impact on the level of coverage from either Medicare or UnitedHealthcare. It is simply the fastest way to have your Medicare claims processed.

You will know your claims are being processed through Medicare Crossover when you receive your copy of the Medicare Explanation of Benefits. Your copy of the Medicare Explanation of Benefits is verification that your doctor's claim has been sent to Medicare.

You can verify that your claim has been sent to UnitedHealthcare when your copy of the Medicare Explanation of Benefits states that "Your claim has been forwarded to your insurance carrier."

After your claim has been processed by UnitedHealthcare, you will receive an explanation of benefits from UnitedHealthcare.

**Medicare Crossover Enrollment**

You can enroll for Medicare Crossover in two ways:

- mail in the form that you receive from UnitedHealthcare within three months of turning 65; or
- call *UnitedHealthcare* and enroll over the phone.

**Medicare Advantage Plans**

Many areas of the country have Medicare Advantage Plans available for those who have Medicare. If you want, you can waive your Procter & Gamble plan and enroll in a Medicare Advantage Plan. You can re-enroll in the Procter & Gamble Plan if you decide you do not want to remain in the Medicare Advantage Plan.
Eligibility Due to Age

Individuals become eligible for Medicare when they reach age 65 or as a result of extended disability.

When you enroll in Medicare, Medicare becomes the primary plan and the P&G Retiree Health Care Plan becomes the secondary plan.

Eligibility Due to Disability

If you, your spouse or dependent become disabled prior to reaching age 65, Medicare will become your primary plan.

Your P&G Retiree Health Care Plan will be your secondary plan as long as you are covered under that Plan.

You must notify the Employee Service Center of early Medicare eligibility due to disability for yourself, spouse or dependent. P&G will notify Fiserv Health so that premiums can be reduced and a new coupon book mailed.

Eligibility Due to End Stage Renal Disease

If you or anyone covered by the Plan, regardless of age, receive kidney dialysis treatments and/or a kidney transplant as a result of end stage renal disease, you may qualify for Medicare. Medicare becomes your primary plan after the first 30 months of dialysis.

Once Medicare is primary, any charges or parts of charges not covered under Medicare may be submitted to the P&G Retiree Health Care Plan as the secondary plan. When the Company's plan is secondary, benefits are coordinated with Medicare's payment policy.

Spouse of a Retired Employee

If your spouse becomes eligible for Medicare due to his or her age or disability, Medicare will become your spouse's primary plan and the P&G Retiree Health Care Plan will be the secondary plan.
Coordination With Other Coverage

When P&G's Plan is the secondary plan, it will only pay benefits for allowed expenses if its benefits exceed the payment from the primary plan. Note that claims should always be filed with the primary plan first.

Payment works as follows:

- the Plan determines the amount it would pay on a claim if it were primary; then
- if there is a difference between the amount payable by the primary plan and the amount that the Plan would have paid as a primary plan, P&G's plan will pay the difference.

As a result, benefits paid will never exceed what the Plan would have paid had it been the only coverage.

Members who have another carrier for primary prescription benefits may request to have their claims coordinated between their primary plan and the P&G prescription plan. To request coordination of prescription benefits, submit a copy of the pharmacy payment receipt and a copy of the Explanation of Benefits (EOB) or other documentation of payment from the primary carrier (if provided) to UnitedHealthcare. The claim will be reviewed to determine if any secondary benefit will be paid under the P&G plan.

Rules of coordination for dependents vary with the circumstances.

Note: Even if your P&G Plan is the secondary Plan, you must follow any required notification/authorization procedures to receive full benefits from the P&G Plan.

Children of Participant

If your child is covered under your P&G Retiree Health Care Plan and your spouse's plan, his or her primary plan is determined by the birthday rule: your child is covered primarily by the plan of the spouse whose birthday falls earlier in the year.

Note:
If both birthdays are on the same day, the plan which covered the parent longer pays first. However, if one coordinating plan uses the birthday rule and the other...
uses the male/female rule (father's plan is primary), both plans will follow the male/female rule. This provision avoids the possibility that both plans will be primary or that both plans will be secondary.

Submit the claim first to whichever plan is primary. Then, file a claim with the other plan, along with a copy of the primary plan's *Explanation of Benefits* and a copy of the itemized bill.

**Divorce Decree/Joint Custody**

If there is a divorce decree or joint custody decree which specifies responsibility, the *primary plan* is the plan of the parent who is responsible for coverage according to the decree.

If there is no decree that specifies responsibility:

- the plan of the parent with custody pays first;
- the plan of the spouse of the parent with custody (i.e. the step-parent) pays second; and
- the plan of the parent without custody pays last.

**In all cases**, claims are first submitted to the primary plan. Then they are submitted to the secondary plan with the *Explanation of Benefits* from the primary plan. An individual may not be covered by more than one plan member.

**Dependents with Individual Coverage**

As a retiree of Procter & Gamble, your P&G Plan is your primary plan, and all your claims must be filed with this Plan first.

If another person enrolled in your plan is also covered under his or her own plan, claims should be submitted to that plan first. When that claim has been processed, you may submit a claim for his or her excess charges, along with the *Explanation of Benefits* (*EOB*) and a copy of the provider's itemized bill, to your P&G Plan.

Any plan without a coordinating provision is always primary. When both plans have coordination provisions:
• the plan covering the person as the subscriber is primary. The plan covering the person as a dependent is secondary.
• the plan covering the person as an active employee (or as the active employee's dependent) is primary. The plan covering the person as a retired employee (or as the retired employee's dependent) is secondary. If both plans do not have this rule, and if, as a result, the plans do not agree on the order of benefits, previously described rules apply.

Different rules apply if both you and your spouse cover your children or if you are divorced and cover your children.

Note: If none of the rules mentioned in this plan determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.
Cost/Contribution

You and the Company share the cost of coverage. P&G reviews premium amounts annually. Any increase or decrease remains in effect for a twelve-month period, beginning July 1.

To participate in the Retiree Health Care Plan you must live in the United States and pay a monthly contribution. You will receive a premium coupon booklet and your new Retiree Health Care Plan card shortly after retirement.

If you choose, you can have your Retiree Health Care Plan premiums automatically deducted from your designated bank account. Complete the "Automated Payment Authorization Form" and attach a voided personal check from the account. Deductions will be taken from your account on the third work day of each month. Contact Fiserv Health to get a copy of the form.

Note:
Beginning with the first month of Medicare eligibility, Medicare becomes your primary coverage and the premium rate for the Retiree Health Care Plan is reduced.

Spouse/Dependent Fee When Other Coverage is Available

When your spouse or dependent has other medical coverage available at a cost of 50% or less of the cost of that plan, he or she must enroll in that coverage. If that individual elects not to enroll and you cover him or her under your P&G plan, your P&G monthly premium contribution will be increased by $80/month for each applicable person.

For example, if your spouse's plan total cost is $200 and your spouse pays greater than or equal to $101, the additional fee is waived because your spouse is paying more than 50% of the total cost. However, in the same example, if your spouse is paying 50% of the total cost, you are responsible for the fee.

The additional $80/month will also apply if your spouse's employer (or previous employer) is paying him or her not to take their health care coverage.
Note:
The additional $80/month cost for covering your spouse or dependent who has other medical coverage will **not** apply if:

- he or she is not yet eligible to enroll for the other medical coverage, such as having to wait for an Annual Enrollment date; or
- the cost to your spouse or dependent of the other medical coverage is **higher** than 50% of the cost of that plan.

If your spouse enrolls in his or her employer's medical plan, you may enroll your spouse or dependents in P&G's family coverage using coordination of benefits.
Eligibility

You are eligible for the Plan if:

- you were a *full-time* employee;
- you live in the United States (maintain permanent residency for more than six months a year);

  - you retired at age 55-59 *and* the sum of your age plus years of service was equal to 75 or more; or

  - you retired at age 60 or older *and* your years of service equaled ten or more; or
  - your date of hire was before June 1, 1993, and you retired at age 65 or older with at least one year of service;
  - you were not terminated "for cause".

- You go to work for a "successor employer" who contracts with Procter & Gamble to do work for Procter & Gamble as a third party contractor (that is, you and your work move to this third party) and if, at the time that you separate from Procter & Gamble, you:
  - qualify as a regular retiree; or
  - Meet the requirements as a special retiree as defined by Procter & Gamble. The current definition is the Rule of 70 (full years of service at Procter & Gamble plus full years of age, as of the agreed date of the separation, equal at least 70). Procter & Gamble reserves the right to amend this definition.

While still employed by the "successor employer", your Procter & Gamble Retiree Health Care Plan can only be considered as your secondary health care coverage,
not your primary coverage. Upon leaving the "successor employer" at any time for any reason, your Procter & Gamble Retiree Health Care Plan can then be your primary coverage.

If you are eligible for coverage, your spouse, dependent children, qualified household dependents (beginning 1/1/99), and qualified domestic partners, are eligible for coverage if they meet eligibility requirements.

Spouses, dependent children, qualified household dependents and/or qualified domestic partners must reside in the United States or U.S. sovereign territories and must be U.S. citizens or permanent residents. Individuals who are in the U.S. on temporary visas, such as tourist or medical visas, are not eligible for coverage.

A surviving spouse and any covered dependents of a deceased retiree may continue their same coverage (and rates) for 12 months following the retiree's death. After the 12-month period, the surviving spouse may enroll in the National Surviving Spouse Health Care Plan or COBRA. The covered dependents are eligible for COBRA.

A surviving spouse of a deceased active employee who is eligible for retirement, may enroll in the National Surviving Spouse Health Care Plan or COBRA following the 12-month active coverage extension. The covered dependents are eligible for COBRA.

A surviving qualified domestic partner of a deceased active employee who is eligible for retirement, and who is enrolled in the employee's Procter & Gamble health care plan at the time of the employee's death may enroll in the National Surviving Spouse Health Care Plan or COBRA following the 12-month active coverage extension. The covered dependents are eligible for COBRA.

A surviving qualified domestic partner who is enrolled in Retiree Health Care at the time of the retiree's death and any covered dependents of a deceased retiree may continue their same coverage and rates for 12 months following the retiree's death. After the 12-month period, the surviving qualified domestic partner may enroll in the National Surviving Spouse Health Care Plan or COBRA. The covered dependents are eligible for COBRA.
No household dependents may be added to retiree health care.

**Note:**
If you want to cover any of your dependents, you must elect coverage for yourself. You **cannot** elect coverage for dependents only. Enrollment by the retiree in a Medicare Alternative Plan (formerly Medicare+Choice) is an exception in that the retiree's dependents can continue to be enrolled in the UHC Preferred Provider Plan (PPO) or UHC Base Plan.

Contact *UnitedHealthcare* for more details.

Failure to notify P&G within 15 days of any change in status of a covered person, or false representation of the facts pertaining to the person's eligibility at the time of enrollment, or during the period of coverage, are serious matters. Any benefits paid by P&G for services rendered to a person may be recovered from the retired employee in full if the person was no longer eligible for coverage at the time the services were rendered, or the person was never eligible for coverage.

**Children**

For purposes of eligibility for health care coverage, children include:

- your unmarried children:
  - up to age 19, or up to age 25 if they depend on you for more than one-half of their support; or
  - who are physically or mentally disabled, age 25 or older.

No individual may be covered by more than one P&G health care benefits plan.

Children means your natural children, stepchildren who live in your household for at least six months of the year, children for whom you have legal guardianship, foster children and legally adopted children. Grandchildren are not covered by the Plan unless legal guardianship has been obtained or they continue to meet the criteria for household dependent after the date of retirement.

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You may be required to provide documentation of dependent child eligibility. Verification requirements for children may include birth or adoption certificate, proof of residence, proof of legal guardianship, etc.
Disabled Children

A physically or mentally disabled child who has become disabled while an eligible dependent, receives more than one-half his or her support from you and who is incapable of self support, may be eligible as a child dependent past age 24.

Self support includes possible sources of income such as employment earnings, trust funds, payments from insurance companies, investment earnings, etc. You **must** apply for continued eligibility within 31 days of the disabled child’s 25th birthday.

You are required to provide proof that the child is and remains disabled and is and remains unable to provide self support. Contact your carrier’s customer service to obtain forms to apply for incapacitated dependent status.

Spouses and dependent children must reside in the United States or U.S. sovereign territories and be U.S. citizens, permanent residents, or authorized to be in the U.S. for extended periods by way of valid long-term visa. Individuals who are in the U.S. on temporary visas, such as student, tourist, or medical visas, are not eligible for coverage.

P&G Dual Career Married Employees

If you and your spouse are both eligible retired employees, each of you may choose single coverage or one of you may waive coverage and be enrolled as a dependent of the other retired employee. If a retiree waives coverage and is covered under the spouse’s plan, the retiree who waived coverage is eligible for enrollment in the Retiree Health Care Plan at any time, to include at the spouse’s death.

Spouse

For purposes of eligibility for health care coverage, you may enroll your spouse (who is not legally separated) in this Plan.

Spouse includes a husband or wife as defined or recognized under State law for purposes of marriage in the state where the employee resides, including common law marriage in states where it is recognized.
You may be required to provide documentation of spouse eligibility.

Spouses and dependent children must reside in the United States or U.S. sovereign territories and be U.S. citizens, permanent residents, or authorized to be in the U.S. for extended periods by way of valid long-term visa. Individuals who are in the U.S. on temporary visas, such as student, tourist, or medical visas, are not eligible for coverage.
Plan Details

The Plan allows you to use any provider you choose. In addition, special programs for transplants and care management (care coordination) are available if you should need them.

Under the Plan, you share in paying your medical expenses through deductibles and coinsurance. These deductible and coinsurance amounts apply to all eligible expenses.

After you satisfy your deductible, the Plan reimburses 80% of eligible expenses and you pay the remaining 20% coinsurance. To protect you from large medical bills, the Plan limits your out-of-pocket covered medical expenses.

The Plan also provides access to a Preferred Provider Organization (PPO) network of providers for non-Medicare eligible members. Providers have agreed to discounted rates for their medical services. These reduced rates will provide savings in out-of-pocket expenses if you voluntarily utilize participating providers. You can access the providers if you live near a local network area, if you are traveling or have children away at school. You can locate participating providers by calling UHC Customer service or by visiting the UHC website- www.provider.uhc.com and selecting the PPO product for your search.

In order to participate, you must enroll within 60 days of your retirement date. If you enroll in one of the P&G Retiree Health Care Plans, you will receive plan ID cards usually within 2 - 3 weeks of UnitedHealthcare receiving the enrollment data. You will receive 2 plan ID cards with the retiree’s name on both cards. (1 card for single coverage) These cards should be presented whenever you receive medical services.

You can also waive coverage and return to the plan later if you meet all of the re-enrollment requirements.

Once you become eligible for Medicare, that becomes your primary coverage. Then, benefits under the Company-sponsored Plan are coordinated with Medicare Parts A and B.
Special Programs

Procter & Gamble provides two special programs to assist you in obtaining optimal medical care in the most cost effective manner.

- **Medical Care Management** (also referred to as Care Coordination) provides assistance for a catastrophic injury or illness for which inpatient hospitalization or a large amount of covered medical expenses are expected to continue over a long period of time.

- **The Organ Transplant Program** provides a network of nationally recognized facilities that have the experience, training and support services necessary to perform transplantation medicine, including heart, lung, heart/lung, liver, pancreas, pancreas/kidney, kidney, multivisceral and small bowel human organ transplants, as well as any organ not listed but required by law. Cornea transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Plan benefits and are subject to other applicable provisions of the Plan.

Medical Care Management/Care Coordination

If you or anyone covered by the P&G Medical Plan is hospitalized due to a severe injury or illness, you may be eligible to participate in a Care Management (also referred to as Care Coordination) Program which is designed to help identify alternatives to a long-term hospital stay.

Under Medical Care Management, (Care Coordination) health care professionals analyze your case and may suggest possible treatment alternatives that are more advantageous, more convenient and often less expensive. In some cases, recommendations by this program can ensure payment for alternatives that may not be covered otherwise.

All Medical Care Management (Care Coordination) professionals are highly qualified and have extensive rehabilitation experience. They will evaluate your case and assure that you receive the most appropriate care for your condition. They also work closely with ancillary providers to help you find home nursing care or durable medical equipment.
However, if you prefer, you do not have to accept these recommendations. You, your family and your physician are responsible for making decisions about your health care. Medical Care Management (Care Coordination) is designed to suggest possible alternatives which you may not have otherwise considered.

Your P&G Medical Plan will identify any situations where this program can be helpful. They will contact your doctor directly to discuss your situation.

**Organ Transplant/Bone Marrow Transplant Coverage Information**

Procter & Gamble recognizes that solid organ and bone marrow transplants are serious medical procedures that require expert providers. We utilize a network of quality facilities located across the United States with clinically renowned transplant programs. The programs were selected based on a number of factors, including successful outcomes, annual case volumes, the transplant team's expertise, the one-year post-transplant survival statistics and geographic location.

If you or a covered family member needs a transplant, your P&G Medical Plan will provide you with information about the appropriate transplant facility. You will select the facility that's best for you.

The types of Organ Transplant services covered include, but are not limited to:

- obtaining and evaluating the donor organ;
- removing the organ from the donor;
- transporting the organ to the site of the transplant operation;
- hospital room and board;
- hospital services;
- doctor's services;
- transportation to and from the nearest transplant center authorized to perform the transplant;
- lodging expenses;
- medical expenses of a living donor associated with providing an organ to a covered member of the Plan.

Post-transplant prescription medications are covered under the Prescription Medication provisions of the Plan, not under the medical coverage.
The Plan covers the costs of heart, lung, heart/lung, liver, pancreas, pancreas/kidney, kidney, multivisceral and small bowel human organ transplants, as well as any organ not listed but required by law. Corneal transplants and porcine heart valve implants, which are tissues rather than organs, are considered part of regular Plan benefits and are subject to other applicable provisions of the Plan. Other transplants may be covered under the Plan in the future if they prove to be successful. Contact the Carrier for information concerning possible coverage of other transplants. The Plan also provides benefits for *allogeneic* and *autologous* bone marrow transplants for certain diagnoses.

**Bone Marrow Transplants**

*Allogeneic* bone marrow transplants are eligible only when in relation to diagnoses of:

- aplastic anemia;
- acute leukemia;
- severe combined immunodeficiency, e.g., adenosine deaminase deficiency and idiopathic deficiencies;
- Wiskott-Aldrich syndrome;
- infantile malignant osteopetrosis (Albers-Schonberg syndrome or marble bone disease);
- non-Hodgkin's lymphoma, intermediate or high grade stage III, or stage IV;
- Hodgkin's disease (lymphoma), stage IIIA or IIIB, or stage IVA or IVB;
- chronic myelogenous leukemia;
- neuroblastoma stage III and IV in children over one year of age;
- homozygous beta-thalassemia (thalassemia major).

*Autologous* bone marrow transplants are eligible only when in relation to diagnoses of:

- non-Hodgkin's lymphoma, intermediate or high grade stage III, or stage IV;
- Hodgkin's disease (lymphoma), stage IIIA or IIIB, or stage IVA or IVB;
- neuroblastoma stage III and IV;
- acute lymphocytic or nonlymphocytic leukemia following a first or subsequent relapse;
- breast cancer (evaluated on a case by case basis).
As additional diagnoses cease to be experimental or investigational, the lists of covered diagnoses may be amended to include such additional diagnoses.

The Plan cannot guarantee that you, or anyone covered by the Plan, will receive a specific organ transplant. There's a limited supply of donors as well as guidelines for determining medical necessity, usually set through governmental regulations or conventional medical practice which govern who may receive an organ transplant. Additionally, organ transplant procedures require notification/authorization.

Refer to the Coverage Information chart for specific Organ Transplant coverage details.

Organ Transplant Services Not Covered

Certain services are not included under the Organ Transplant coverage. Please refer to Exclusions of Services, Treatments and Supplies Not Covered and Prescription Medications Not Covered pages in this Plan for specific details.
Prescriptions

Most FDA approved medications and medications which require a physician's written prescription are covered under the Plan, including insulin.

The Plan pays 70% of covered prescription medication expenses and you pay coinsurance of 30%. After you reach your $1,500 out-of-pocket maximum, the Plan pays 100% of all eligible prescription medication expenses for the rest of the calendar year. There is no deductible to satisfy.

Medicare covers diabetic supplies (insulin is not a supply). If you are on Medicare, your pharmacy may or may not submit your charges for diabetic supplies to Medicare (depending on whether it is a "Medicare Pharmacy"). If it is a Medicare Pharmacy, you will just have to pay 20% (instead of the 30% charged by your P&G plan). If it is not a Medicare Pharmacy, you will need to file a claim with Medicare to get reimbursed. Just ask at your pharmacy how they handle Medicare covered supplies. If you do not have Medicare, you can get your diabetic supplies by using your prescription card at the pharmacy and paying 20% coinsurance.

When OTC equivalents are available, the prescription medication is covered at 100% of covered charges after a 50% member co-insurance per prescription.

The maximum days supply of prescription medication which may be purchased through home delivery is a 120-days supply per prescription and a 34-days supply per prescription through a retail pharmacy.

In cases of extended travel to regions where participating pharmacies are not available, an exception to the quantity limit may be requested. Federal regulations may prohibit limit exceptions for certain medication.

Always have your health care ID card with you when you obtain prescriptions. Otherwise, you will have to pay the full charge and get an itemized receipt from your pharmacist to submit for a refund. Your refund may be smaller if you purchase your prescriptions without using your health care ID card because you will not necessarily get the discounted rate without using your health care ID card.

Prescription Medication That Have Over-The-Counter (OTC) Equivalents
Certain prescriptions medications have OTC equivalents. These OTC medications contain the same amount of active ingredients (medicinal components) in the same dosage form as the prescription medications, sometimes with minor differences in the non-active ingredients such as colors or flavors. Often the OTC medications cost significantly less than the prescription medications. P&G will provide 50% coverage for prescription medications with OTC equivalents and retirees are responsible for the remaining 50% which does not count toward meeting the prescription medication plan $1,500 out-of-pocket maximum.

Examples of prescription medications that have OTC equivalents include:

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name (all brands may not be listed)</th>
<th>OTC Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ammonium Lactate 12% lotion and cream</td>
<td>Lac-Hydrin 12% lotion and cream</td>
<td>AmLactin 12% lotion and cream</td>
</tr>
<tr>
<td>Benzoyl Peroxide 2.5, 5, 10% gel; Benzoyl Peroxide 5, 10% cream</td>
<td>Benzac 2.5, 5, 10%; Desquam 2.5, 5, 10%; Panoxyl 2.5, 5, 10%</td>
<td>Oxy 10 Balance; Fostex</td>
</tr>
<tr>
<td>Benzoyl Peroxide 10% liquid</td>
<td>Benzac 10, Desquam 10</td>
<td>Dryox 10, Oxy 10</td>
</tr>
<tr>
<td>Psuedoephedrine/Quaifenesin</td>
<td>Guaifed</td>
<td>Robitussin PE</td>
</tr>
</tbody>
</table>

NOTE: This list is subject to on-going change as medications are developed, changed or become available without a prescription.

Use of Food and Drug Administration (FDA) Dose and Quantity Standards

The FDA provides recommended safety standards for age-related dosages and quantity limitations for prescription medications. FDA standards will apply to all prescription medications. Individuals who have prescriptions that do not follow FDA standards will be notified by the pharmacist of the need to have their prescribing provider contact the prescription medication carrier before coverage may be provided for nonstandard prescriptions.

Prescription Medications that Require Prior Authorization for Coverage

For certain medications that are prescribed for more than one health condition, prior authorization will be required. The Prescription Medication Plan will require that your physician verify the intended purpose for these medications. Contact the Carrier to obtain specific details concerning when and how prior notification/authorization should be obtained.
Home Delivery

When your doctor prescribes a maintenance medication for you, you may use a local retail pharmacy or the UnitedHealthcare Rx home delivery prescription program to fill the prescription. The home delivery prescription program offers a number of advantages including:

- the ability to obtain larger quantities of maintenance medications. The home delivery prescription program allows for up to a 120-day supply per medication, while the retail plan is limited to no more than a 34-day supply at one time;
- lower cost to you and the Company for brand medications and many generic medications due to higher discounts on home delivery for Brand medications and many generic medications;
- the convenience of using the telephone or internet to order your refills;

When you use the home delivery prescription program, you pay a copayment per prescription of 30% with an out-of-pocket maximum of $1500 per year, after which prescriptions are fully paid for by the Plan.

UnitedHealthcare Rx accepts Visa, MasterCard, and Discover/Novus, American Express or Diner's Club cards. You may also pay your co-payment by check or money order. If paying by check or money order, you will need to call UnitedHealthcare, Prescription Medication Division, prior to mailing your order to find out how much your co-payment will be.

To take advantage of the home delivery prescription program, you should call UnitedHealthcare, Prescription Medication Division, to order an information packet.

Retail Pharmacies

Your cost for prescription medications should always be the lower of either the UHC discounted price or the pharmacy discounted price.

For most prescriptions or refills, coverage is up to a 34-day supply. The Plan contains a number of prescription medications identified as generic medications. At your discretion, these may be substituted for the brand written on the prescription.
Since generic medications usually cost less than brand name medications, your copay will be lower.

**Note:**
Reduced benefits may be paid if you obtain your prescription or refill at a non-participating pharmacy or do not use your health care ID card when purchasing prescriptions. Check with the pharmacist to confirm whether or not the pharmacy participates in UnitedHealthcare's network.

**Prescription Medications Not Covered**

Expenses for certain medications or services are **not** available through the Prescription Medication Plan, including:

- administration/injection - practitioner's fees for administration or injection of any prescription medication or medicine (medical benefits may apply);
- allergy serums and allergens (medical benefits may apply);
- biological sera (medical benefits may apply);
- blood or blood plasma (medical benefits may apply);
- claims filed after claims filing deadline as described in the Procedures > Claims section of this Plan;
- convalescent facility/nursing home - prescription medications provided for use in a convalescent facility or nursing home which are ordinarily furnished by such facility for the care and treatment of patients;
- cosmetic purposes - medications used primarily for cosmetic purposes, e.g. Rogaine and in certain cases Retin A;
- coverage date - services or supplies provided before the effective date of coverage or after the termination of coverage;
- days supply - home delivery (mail order) - charges for more than 120 days supply of prescription medications obtained via home delivery;
- days supply - retail - charges for more than 34 days supply of prescription medications obtained at retail pharmacies;
- delivery charges;
- exclusions - any expense excluded by the Plan;
- experimental/investigational - medications used for experimental or investigation purposes;
• FDA-approved purposes - medications used for purposes that are not FDA approved unless reviewed and approved with prior authorization;
• FDA-medications that are not approved for general sale by the U.S. Food and Drug Administration (FDA);
• foreign country prescription medication services - non-emergency services rendered outside of the United States or U.S. sovereign territories. Coverage is provided for covered members who experience emergency illness or injury while on temporary travel to foreign countries;
• growth hormones except when determined to be medically necessary by the Plan;
• hospitalization - prescription medications used as an inpatient or outpatient in a hospital which are ordinarily furnished by such facility for the care and treatment of patients;
• immunizations (medical benefits may apply);
• infant formula;
• infertility medications;
• licensure - medications that are not dispensed by a licensed pharmacist or physician;
• lifestyle-related activity enhancement - medications used to enhance lifestyle-related activities such as sexual function or performance, dieting, and smoking cessation;
• medical condition - medications and supplies when not indicated or prescribed for a medical condition as determined by the Plan or otherwise specifically covered under the Plan;
• medical supplies, devices and equipment and nonmedical supplies or substances regardless of their intended use except for diabetic devices, supplies and equipment covered under the Plan;
• non-covered expenses - expenses for medications that have been determined as non-covered through authorization, concurrent or retrospective review, and/or appeal review;
• nutritional supplements except in situations where supplements are the only source of nutrition for an individual and the condition was caused by a medical disease or injury;
• over-the-counter - medications which can be purchased over the counter (without a prescription);
• packaging - convenience packaging charges/extra costs;
• payment - any covered medication, device, or apparatus for which you are not legally obligated to pay or for which no charge is made;
• payment - charges which are in excess of the contracted amount;
• payment - prescription medications that may be received without charge under local, state or federal programs, including Worker's Compensation;
• payment - prescription medications when another plan, person or third party has the obligation to provide funds for payment;
• payment - prescription medications when, in the absence of this certificate you would not be charged;
• prescription medications that are 100% equivalent in active and inactive ingredients to an over-the-counter medication, but have a different name than the OTC;
• prescription order requirement - medications that do not require a prescription order and/or which are not prescription legend medications, except insulin;
• refills - any refill in excess of the amount specified by the prescription order. Before covering charges, the Plan may require a new prescription or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards or FDA standards;
• refills dispensed more than one year from the date of the prescription;
• replacement medications resulting from loss, theft, or damage;
• residency - medications or services for employees or retirees and dependents residing outside of the United States or U.S. sovereign territories;
• skin pigmentation - pigmenting or depigmenting agents;
• smoking cessation - medications or devices used to assist with smoking cessation;
• test agents and devices (exception - diabetic test agents);
• United States - medications obtained outside of the United States or U.S. sovereign territories (exception - medications required as part of one-time emergency or urgent care treatment);
• vitamins or minerals, except those which by federal law require a prescription for dispensing;
• weight loss - medications used to assist with weight loss;
• work-connected injuries or diseases - prescription medications or supplies used to treat work connected injuries or diseases eligible for coverage by Worker's Compensation or similar law or eligible for Medicare payment, whether or not coverage is elected.
Procedures (How To)

Appeals

If you would like to appeal a denial of your request to enroll, you should appeal in writing to the Healthcare Benefits Manager.

You should include the following information in your letter of appeal of a request for enrollment:

- Retiree Name
- Retiree Alternative ID #
- Retiree daytime telephone number
- Name of individual who was denied enrollment
- Relationship of individual to retiree
- A brief explanation of why you disagree with information given in the denial

You will be given two opportunities to appeal of your request to enroll. The second appeal will not be decided by the individual who determined the outcome of your first appeal.

Appealing a Denied or Reduced Claim for Medical Benefits

The reason your claim was denied or benefits were reduced is indicated on the Explanation of Benefits, (EOB) that you received from UnitedHealthcare (the Carrier). You have the right to appeal a claim denial or payment reduction if you feel that the reasons for the denial or reduction are not valid. Your first step is to call the Carrier customer service line to attempt to resolve any differences. This initial call does not qualify as an appeal. If you are not satisfied with the resolution of your call, you should file an appeal in writing to the Carrier.

In order for your appeal to be considered, you must file your written appeal within 180 days of the service. You should attach copies of any documents concerning your case, and include the following information in your appeal letter:

- Patient Name
- Subscriber Name
- Subscriber Alternate ID #
2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

- Date of Service
- Provider's Name
- Claim Number (located on the EOB)
- The reason for your appeal

During the appeal process, you are entitled to review all appropriate plan documents and to have a qualified person represent you. You will be notified of the decision concerning your appeal.

If you are not satisfied with the outcome of your first written appeal, you may file a second written appeal with the Carrier.

Those involved in the first appeal decision will not decide the second appeal. In this letter, you should describe the problem in detail, and attach copies of any documents you have concerning your case. You will be notified of the decision concerning your appeal.

Procter & Gamble will not be involved in decisions concerning denied or reduced claims, and will not accept appeals.

**Appealing a Denied or Reduced Claim for Prescription Medications**

For retail and home delivery appeals contact *UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)*.

You have the right to appeal a claim denial or payment reduction if you feel that the reasons for the denial or reduction are not valid. Your first step is to call the Carrier customer service line to attempt to resolve any differences. This initial call does not qualify as an appeal. If you are not satisfied with the resolution of your call, you should file an appeal in writing to the Carrier.

In order for your appeal to be considered, you must file your written appeal within 180 days of the service. You should attach copies of any documents concerning your case, and include the following information in your appeal letter:

- Patient Name
- Subscriber Name
- Subscriber ID #
During the appeal process, you are entitled to review all appropriate plan documents and to have a qualified person represent you. You will be notified of the decision concerning your appeal.

If you are not satisfied with the outcome of your first written appeal, you may file a second written appeal with the Carrier.

 Those involved in the first appeal decision will not decide the second appeal. In this letter, you should describe the problem in detail, and attach copies of any documents you have concerning your case. You will be notified of the decision concerning your appeal.

Procter & Gamble will not be involved in decisions concerning denied or reduced claims, and will not accept appeals.

**Appealing a Notification/Authorization For Care Decision**

If you or your attending physician disagrees with a decision regarding the appropriateness of a treatment plan, or the necessary length of services, contact UnitedHealthcare for the procedure to appeal the decision. If agreement cannot be reached, it is your decision on whose advice to follow. The Plan, however, will pay benefits according to the decision made by the claim administrator.

Procter & Gamble will not be involved in decisions concerning notification/authorization of care and will not accept appeals.

**Assignment**

Payments to most physicians and hospitals may be assigned. However, payments to pharmacies may not be assigned.

For additional information on which benefits can be assigned, contact UnitedHealthcare.
Change of Address

To change your address, contact the Employee Service Center.

If your move changes your zip code, you may have moved out of your health care plan's service area and may need to change to a new plan. Contact UnitedHealthcare to determine whether your current plan is available in your new area. If a change is necessary, contact the Employee Service Center immediately.

Address changes will be shared throughout the Company except Shareholder Services.

Claims

To receive reimbursement for a medical claim, you should submit your bills to UnitedHealthcare as you receive services, rather than letting them accumulate. You do not need a UnitedHealthcare claim form each time you submit bills.

Your doctor or hospital may want to submit your bills directly. The following items must be included for a claim to be processed:

- an itemized bill that includes the name of the provider, dates of service, diagnosis code, treatment code and charges. A financial statement that summarizes the dollars charged is not sufficient for a claim to be processed;
- the UnitedHealthcare address, which is on the back of your identification card;
- the group number on the front of your identification card;
- the retiree's Alternate ID number on the front of the identification card;
- the patient's name; and
- if you have received services from a nurse or therapist, your claim should include a statement from your doctor explaining why these services were needed.

If your provider sends claims electronically, the payor ID number (87726) for UnitedHealthcare must be included. Electronic claims are the fastest way to have your claim processed.

To file a claim for a prescription from an out-of-network pharmacy, obtain a claim form from the Employee Service Center or the Champions website (www.champions.com)}
www.pg.com/champions). Complete the form, attach receipts and mail it to UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.).

You should consider the following when filing a claim:

- your bills do not have to be paid before you file a claim. However, some providers may require payment in full at the time of service. Be sure to include a bill, not just a cancelled check;
- you may designate benefits to be paid directly to you or to the provider;
- file separate claims for each family member and for each provider and
- if another insurer is primary, attach the other insurer's Explanation of Benefits statement to your claim and mail the completed claim to UnitedHealthcare.

You should keep copies for your records of any documents you send.

In order to receive coverage, all claims should be filed within 90 days after you, or anyone covered by the plan, receives a covered service or supply. You must file a claim for covered medical services no later than one year after this 90-day period. You must file a claim for covered prescription services no later than one year from the date of service.

If your claim is denied, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

Checking Status/Processing Time

You should receive any reimbursement, or if you assigned benefits, notification of payment to the provider, as soon as possible. Typically, claims are processed within 30 days of submission.

For information on the status of a claim, contact UnitedHealthcare, or visit UHC's website at www.myuhc.com.

Claim Payment From Another Source (Subrogation)

If your Plan has paid a claim for you or a covered family member, and you have the right to receive or you actually received payments for that claim from another party,
P&G has the right to receive a refund from you. Examples of this legal process, called *subrogation*, are payments resulting from traffic accidents in which another party's automobile insurance is responsible for health care costs.

You must inform UnitedHealthcare of a potential or actual payment from another source. In addition, you and your legal representative must do what is necessary to enable the Plan to participate in any recovery efforts or actual recoveries.

If the Plan has paid a claim for you or a covered family member and you later receive any form of payment from another source, like automobile insurance, you must return the claim payment to the Plan.

For further information concerning subrogation, contact *UnitedHealthcare*.

**Where to Submit Claims First**

As a retiree of Procter & Gamble, your P&G Retiree Health Care Plan is your *primary plan*. When you reach age 65, Medicare becomes primary.

File your claim with your primary plan first. If your claim is not completely covered, you can submit a claim, along with a copy of the *Explanation of Benefits* (EOB), to your *secondary plan*.

If a dependent is covered under more than one medical plan, where you file his or her claim depends upon which plan is the primary plan for that individual. Refer to Coordination of Benefits for more details.

**Enrollment**

To enroll in medical, complete the P&G Retiree Health Care Enrollment/Change Form. If you decide to enroll for medical coverage and there is a UHC Preferred Provider Plan (PPO) network available within your zip code area, you may **not** enroll in the UHC Base Plan if you are not Medicare-eligible. You **must** elect the UHC Preferred Provider Plan (PPO).

You will be given a Retiree Health Care Enrollment/Change Form upon retirement. To participate or to waive coverage, return the completed form to the *Employee Service Center within 60 days* of your retirement. If you do not enroll within the
qualified enrollment window or meet the requirements to enroll after waiving coverage, you will not be permitted to enroll unless you meet Eligibility of Insurance (E of I) requirements. Call the Employee Service Center for information and to receive an application for an E of I.

If you want to cover any of your dependents, you must elect coverage for yourself. You cannot elect coverage for dependents only. You may elect different participant levels for medical and dental coverage (i.e. family Dental and retiree-only Medical).

If you enroll in this P&G Retiree Health Care Plan, you will receive 2 Plan ID cards, if family coverage or 1 card if single coverage, (generally within 30 days) of the date you enroll. These cards should be presented whenever you receive medical services. ID cards are not issued to Dental Plan participants.

If you need additional ID cards, contact the carrier.

Failure to notify P&G within 15 days of any change in status of a covered person, or false representation of the facts pertaining to the person’s eligibility at the time of enrollment, or during the period of coverage, are serious matters. Any benefits paid by P&G for services rendered to a person may be recovered from the retired employee in full if the person was no longer eligible for coverage at the time the services were rendered, or the person was never eligible for coverage.

Changing Status

Should anything change in your status, i.e., dependents, marriage, divorce, death, work status, etc., contact the Employee Service Center. Any change to your benefits which you make as a result of a special enrollment situation must be requested within 60 days of the effective date (90 days for newborns).

Waiving Coverage

If coverage is waived when you (or your eligible dependents) are first eligible, you (or your eligible dependents) must meet the following conditions to enroll in the future. Dependents must also continue to meet eligibility requirements. You must:

- provide documentation showing that coverage was provided through another employer group health plan during the entire waiver period;
· apply within 60 days of the loss of other coverage; and
· if you do not meet the first two conditions, Evidence of Insurability requirements must be met to enroll.

If you waive coverage in order for you or a dependent to enroll in a Medicare Advantage Plan you need to notify the Employee Service Center. If you later want to re-enroll in a P&G plan and disenroll from the Medicare Advantage Plan, you need to notify P&G before your Medicare Advantage Plan coverage ends.

Note:
Coverage under COBRA during the entire waiver period fulfills the requirement of coverage under another employer group plan.

Health Insurance Portability and Accountability Act (HIPAA) Certificate

The Certificate of Creditable Coverage is issued when:

· you submit a Health Care Enrollment/Change Form to drop a dependent or yourself from coverage; or
· you terminate employment with Procter & Gamble.

When you begin a new job, or enroll in new health care, be sure to contact your new employer or health plan administrator as soon as possible to see if they need the certificate. If your new health plan does not require the certificate, you should keep it in your records until you need it.

Contact the HIPAA Administrator if you or your dependent drop coverage but do not receive a Certificate of Creditable Coverage.

Note:
If you lose your certificate within 24 months of your health care coverage end date, be sure to contact the HIPAA Administrator for a duplicate copy. A copy will be mailed to you at no charge.

Notification/Authorization

When specific services, supplies, medications or treatments are going to be obtained, a call must be placed to the Carrier prior to utilization of such services,
supplies, medications or treatments, in order to obtain coverage details and/or provide appropriate information needed to correctly administer a claim. Notification/authorization does not guarantee that a service, supply, medication or treatment will be covered by the Plan.

The notification/authorization procedure is designed to help you avoid unnecessary, lengthy or costly hospitalizations or treatments when there may be appropriate alternatives.

Each time you receive care, you are responsible for following all notification/authorization procedures. If you fail to call the Carrier for notification/authorization (and the expenses for services are covered by the Plan), your benefits will be reduced by 30%. If you extend the number of certified hospital days without notification/authorization, no benefits will be paid.

Refer to the Coverage Information chart to determine the types of services, supplies, medications or treatments that require notification/authorization. If you extend the number of certified hospital days without notification/authorization, or if you do not obtain the required notification/authorization for inpatient behavioral health services, no benefits will be paid.

Pre-admission notification/authorization helps to control inpatient costs by helping you avoid needless or unnecessarily long inpatient stays by:

- reviewing with you possible options such as the outpatient surgery and second opinion provisions that can help hold down health care costs and may affect your benefits;
- reviewing the reasons for an inpatient stay with your doctor to make sure it is necessary. In many cases, such as non-surgical treatment, minor surgery or diagnostic testing, you can receive treatment without a hospital stay;
- making sure that testing is done before the inpatient stay begins, if at all possible;
- assigning an estimated duration for your inpatient stay and monitoring its length; and
- developing alternative treatment options such as skilled nursing facilities and comprehensive rehabilitation centers.
If you disagree with a notification/authorization decision, you may appeal the decision by filing an appeal with the Carrier. See the Procedures, Appeals section of this Plan for more information on the appeals process.

Notification/Authorization procedures differ once you become covered by Medicare.

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Notification/Authorizations Before You Have Medicare</th>
<th>Notification/Authorizations After You Have Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital admissions</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
<tr>
<td>Hospice (in home or in facility)</td>
<td>Not required</td>
<td>Not required</td>
</tr>
<tr>
<td>Inpatient rehabilitation</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
<tr>
<td>Home health care</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
<tr>
<td>Private duty nursing</td>
<td>Notification/Authorization required</td>
<td>Notification/Authorization required</td>
</tr>
<tr>
<td>Home IV therapy</td>
<td>Notification/Authorization required</td>
<td>Notification/Authorization required</td>
</tr>
<tr>
<td>Reconstructive procedures:</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
<tr>
<td>-Blepharoplasty, upper lid</td>
<td></td>
<td></td>
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<tr>
<td>-Breast reconstruction/reduction</td>
<td></td>
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<tr>
<td>-Ligation, vein stripping</td>
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<tr>
<td>-Sclerotherapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accidental Dental Services</td>
<td>Notification/Authorization required</td>
<td>Not required</td>
</tr>
</tbody>
</table>
Emergency Care/Admission

If you are admitted to a hospital because of an emergency, you, your doctor, a family member or a hospital representative should call the Carrier within 48 hours of the admission.

Contact UnitedHealthcare for more details.

Extending a Hospital Stay

At the time of the initial review of your preadmission notification/authorization, a UnitedHealthcare professional will make a recommendation regarding the length of your stay.

One day before your scheduled discharge, the Plan will contact your doctor to determine how many, if any, additional days will be authorized.

If you exceed the number of certified days, the additional days of hospital confinement will not be covered.

Maternity Admission

For a maternity admission, you should contact UnitedHealthcare prior to your due date for admission procedures and to provide notification/authorization. Call UnitedHealthcare again within 48 hours after you check in to notify them of your admission.

If the Plan is not notified of your maternity admission, benefits shall be reduced by 30%.
On your last certified day, the hospital will be contacted to determine if you are being discharged. If not, the Plan will contact your physician to determine how many, if any, additional days will be authorized.

If you exceed the number of authorized days, the additional days of hospital confinement will not be covered.

**Note:**
Group health plans and health insurance issuers offering group health insurance 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 normal vaginal delivery, or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal Law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

**Non-Emergency Admission**

When your doctor recommends that you stay in a hospital, you must get a Preadmission Authorization. Authorization does the following:

- reviews with your doctor the reasons for inpatient/outpatient services to make sure they are medically necessary;
- discusses possible alternative options to inpatient hospitalization that can help hold down health care costs, and help to maximize your benefits; and
- establishes an appropriate length for your hospital stay. At the time of the initial review, a UnitedHealthcare health care professional will make a recommendation regarding duration, taking into consideration the severity of your illness or injury. One day before your scheduled discharge, UnitedHealthcare will once again contact your doctor/representative and, if it is medically necessary, your stay may be extended.

If you do not follow the required notification/authorization procedures, your benefits will be reduced by 30%.
Readmission to the Hospital

Readmissions to the hospital are treated like any other hospital admission. Refer to the Coverage Information chart to determine the types of hospitalizations that require notification/authorization. You must follow the proper notification/authorization procedure.

If you do not follow the required notification/authorization procedures, your benefits will be reduced by 30%.

Second Surgical Opinion Program

Whenever your doctor recommends non-emergency surgery for you or a covered dependent, you may seek a second surgical opinion. Second surgical opinions are not required by the Plan and are fully covered at 100% (deductible does not apply).

If needed, a third surgical opinion will be covered at 100% to resolve conflicting opinions (deductible does not apply).

QDRO/QMCSO

Qualified Domestic Relations Order/Qualified Medical Child Support Order

If you receive a court order that affects your benefits, you will need to notify Procter & Gamble. The steps you need to take are based on the type of order you receive.

Qualified Domestic Relations Order (QDRO)

Qualified Domestic Relations Orders (QDRO) are sent to Procter & Gamble directly from the County Court. If you receive a court order that affects your benefits, you should contact the Employee Service Center to confirm that Procter & Gamble has received a copy. You will be notified by the Employee Service Center of the steps you need to take based on your QDRO.

Qualified Medical Child Support Order (QMCSO)

Qualified Medical Child Support Orders (QMCSO) are sent to Procter & Gamble directly from the County Court. If you receive a court order that affects your benefits,
you should contact the *Employee Service Center* to confirm that Procter & Gamble has received a copy. You will be notified by the Employee Service Center of the steps you need to take based on your QMCSO.
2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

When Coverage Begins/Ends

When Coverage Begins

Regular Retiree

Coverage for you and any enrolled dependents begins on the first of the month following your retirement date, which is the day after your active coverage ends. The Retiree Plan requires you to live in the United States and pay a monthly contribution. You will receive a premium coupon booklet with which to mail your payments. If you choose, you may have your Retiree Health Care Plan premiums automatically deducted from your designated bank account. Contact Fiserv Health to get a copy of the "Automated Payment Authorization Form". Complete the form and attach a voided personal check from the account. Deductions will be taken from your account on the third work day of each month.

You will receive your new retiree health care card shortly after retirement. Your retiree health care card will also be used for prescriptions. Separate identification cards are not issued for the Retiree Dental Plan.

Even if you are eligible, medical coverage for you and your eligible family members after you retiree will not continue automatically. You must complete an enrollment form and send it to the Employee Service Center.

New Dependent

<table>
<thead>
<tr>
<th>Event</th>
<th>Eligibility begins on the date of the Event if enrollment occurs within this many days of the Event</th>
<th>Eligibility begins on the date P&amp;G processes the enrollment form if enrollment occurs within this many days of the Event</th>
<th>Evidence of insurability required if enrollment is requested this many days after the Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage</td>
<td>1-60 days</td>
<td>Not Applicable</td>
<td>61 days or more</td>
</tr>
<tr>
<td>Birth</td>
<td>1-90 days</td>
<td>Not Applicable</td>
<td>91 days or more</td>
</tr>
</tbody>
</table>
When Coverage Ends

Your coverage will end on the earliest of:

- the end of the month in which you voluntarily withdraw from the Plan;
- the date your Plan or group policy terminates or is changed to end coverage for the class to which you belong; or
- the end of the month in which any required retiree contribution is not made.

Coverage for your spouse or eligible dependents will end on the earliest of:

- the end of the month in which your coverage ends for any reason except death (if you die, your eligible dependents may continue coverage for 12 months after your death);
- the end of the month in which a spouse becomes ineligible because of divorce, legal separation or annulment; or
- the end of the month in which a dependent becomes ineligible because he or she marries; no longer depends on you for at least half of his or her support or reaches the maximum age.
Health Insurance Portability and Accountability Act (HIPAA)

The **Health Insurance Portability and Accountability Act** (HIPAA) is a federal law which enables you and your dependents with certain medical conditions to obtain health coverage from a new employer or from a private health insurance company through limits on pre-existing condition exclusions.

If you and your dependents are enrolled in any P&G Medical Plan and lose coverage for any reason, you will be issued a certificate which states how long you were continuously covered under Procter & Gamble health plans. The amount of your continuous coverage under a previous health plan will reduce the **pre-existing condition** restriction period under your new plan.

Your previous health plan coverage, whether through Procter & Gamble or another health plan, is referred to as "creditable coverage" under HIPAA. In order for your creditable coverage to reduce a new plan’s pre-existing condition exclusion period, you must not go more than 63 days without any medical coverage. Your certificate will be unnecessary once you are covered under a new plan for 18 months.

If you have a question about a certificate sent to you by the Company, you should contact the **HIPAA Administrator**.

If you have a certificate from a previous employer, keep it in a safe place in case you need it in the future. You do not have to give it to anyone at Procter & Gamble since our medical plans do not have pre-existing condition restrictions.

**Definition of Pre-Existing Conditions Under HIPAA**

The following is a basic definition of pre-existing conditions under HIPAA. **Procter & Gamble plans DO NOT have pre-existing condition exclusions.**

A **Pre-Existing Condition Exclusion** is defined as any limitation or exclusion of benefits based on a health condition that existed before the first day of coverage under the plan, whether or not any medical advice, diagnosis, care, or treatment was received before that day.

Under HIPAA, health plans can have a pre-existing condition restriction for a maximum of **12 months**, provided that you enroll within the initial eligibility period.
you enroll after your initial eligibility period, the restriction may be up to a maximum of **18 months**.

- For example, if you had heart surgery two months before starting coverage under your new health plan, and enrolled when first eligible, services related to that surgery could be excluded from coverage for up to 12 months.

However, under the HIPAA rules, that restriction period is **reduced** by the amount of continuous coverage you had previously either through Procter & Gamble or another health plan.

- For example, if your new health plan has a pre-existing condition restriction of 12 months and you had 12 or more months of continuous coverage under your previous health plan, your new health plan must make a determination based on your certificate, regarding your creditable coverage and the length of any pre-existing condition exclusion that applies to you.

**Note:**
The certificate expires after 24 months from the health care end date. If at any time there is a break in coverage of **63 days or more**, the full pre-existing condition limitation allowed by the plan will be imposed.
Administration

Benefit Funding

Our benefit plans are funded as follows:

Medical Plan

Retiree medical plan costs are shared between the Company and the retiree. The retiree’s share can change periodically. Benefits are paid by contract with the appropriate insurance carrier. The money we pay for this coverage goes into The Procter & Gamble Benefit Plan Trust and is managed by the Trustees of this fund.

Dental Plan

Retiree dental plan costs are shared between the Company and the retiree. The retiree’s share can change periodically. Benefits are paid by contract with the insurance carrier. The money we pay for this coverage goes into The Procter & Gamble Benefit Plan Trust and is managed by the Trustees of this fund.

Legal Service

The agent for service of legal processes for benefit Plans is Ms. J.J. Ting, The Procter & Gamble Company, Two Procter & Gamble Plaza, Cincinnati, OH 45202, 513.698.4518. Legal process also may be served on a Plan trustee(s) or Policy Committee member(s) of any Plan (if applicable).

UnitedHealthcare has been hired to process claims under the Plan. UnitedHealthcare does not serve as an insurer, but merely as a claims processor. Claims for benefits are sent to UnitedHealthcare. It processes the claims, then requests and receives funds from us to pay the claims, and makes payment on the claims to hospitals and other providers.

The Procter & Gamble Company is ultimately responsible for providing plan benefits, and not UnitedHealthcare. The Procter & Gamble Company and

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Effective: 01/01/2006
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COBRA

COBRA, the Consolidated Omnibus Budget Reconciliation Act, is a federal law under which employees and dependents are entitled to continue the same health care coverage as was provided before a qualifying event for a specific, limited period of time.

Coverage Information

The coverage you receive under COBRA is a temporary continuation of the same health care coverage as was provided under Procter & Gamble's plans before the qualifying event. Provided you elect COBRA within the required time frames and pay the premiums as required:

- you and your covered dependents are entitled to up to 18 months of continuation coverage in the event of:
  - your termination of employment (for reasons other than gross misconduct);
  - retirement;
  - layoff;
  - reduced work hours; or
  - leave of absence.
- your dependents are entitled to up to 36 months of continuation coverage in the event of losing eligibility through:
  - your divorce/legal separation;
  - your death;
  - your dependent ceasing to be an eligible dependent.

Employee’s Responsibility to Notify P&G of a Qualifying Event

In the event of the qualifying events of divorce/legal separation of employee and spouse or a dependent’s losing eligibility for coverage, you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notification orally or in
writing to Procter & Gamble, Employee Service Center. You must provide your name, employee ID or Social Security number, type of qualifying event, and the date of qualifying event. You will be required to complete additional documentation to confirm this qualifying event. Refer to my.PG.com>Employee Resources>Life Changes>My Family Changes>More. Click on either Divorce/Legal Separation or Ineligible Dependent for complete instructions on what must be done to confirm this qualifying event.

If notification is not received within the specified notification time limits, your dependents who are losing eligibility for coverage may not be able to elect COBRA continuation coverage.

Note:
It is also a qualifying event if the employer undergoes a bankruptcy proceeding under Title 11 of the United States Code, with respect to covered employees who have retired.

If you or your dependent have more than one qualifying event, you or your dependent may receive up to a total of 36 months of continuation coverage, provided the second event occurred during the first continuation period. The 36-month period begins as of the date of the first qualifying event.

For example, if you continued family coverage for 18 months because of your termination of employment and during that time you were divorced, your spouse would be entitled to COBRA continuation coverage for up to 36 months from the date you terminated employment.

Under no circumstance would COBRA continuation coverage be available for more than 36 months.

You can change COBRA coverages by following the same rules that apply to active employees and retirees. For specific information about changing plan coverages, refer to the individual plans.

Disability Extension

If you, or your covered dependent, are determined by the Social Security Administration to be disabled at the time you lose eligibility under the Plan due to a
qualifying event, or one of you becomes disabled during the first 60 days of continuing coverage, there is a special COBRA continuation period available.

Everyone who has continued coverage for 18 months may be eligible for an 11-month extension, for a total coverage continuation period of 29 months.

The 11-month maximum disability extension is granted if:

- the Social Security Administration makes a determination of disability;
- the disability started before the 60th day of COBRA coverage;
- the disability will last at least until the end of the 18-month period of continuation coverage; and
- the disabled individual notifies the COBRA Administrator within 60 days of the date of the determination and before the end of the first 18 months of the COBRA coverage period.

Cost/Contribution

Your out-of-pocket costs for COBRA continuation coverage are equal to the full cost of group coverage, plus a 2% administration fee. Full cost means your prior contribution plus any share paid by Procter & Gamble. You will see your actual costs when you receive your COBRA notification.

Note:
If you are continuing COBRA under a disability extension, the cost for COBRA continuation coverage during the first 18 months is the same as for all other persons continuing coverage under COBRA -- 102% of the full cost. During the 11-month disability extension (months 19 through 29 of coverage), the cost is 150% of the full cost, rather than 102%.

If you need additional information, contact the COBRA Administrator.

When COBRA is elected, the COBRA Administrator will bill you directly on a monthly basis. When making premium payments for COBRA continuation coverage, a check payable to the COBRA Administrator, together with the bill, must be sent to the COBRA Administrator in time to be received by the payment due date.
The first COBRA payment is due within 45 days of the date COBRA continuation coverage is elected. The first payment must be retroactive to the day coverage under Procter & Gamble's plan was lost. Coverage is not active until payment is received.

Thereafter, premium payments must be submitted by the first of the month for which continuing coverage is desired. For example, the premium payment for July would be due by July 1.

Contributions for all COBRA coverages are combined into one payment. Separate payments are not required for each type of coverage elected. If you do not pay the required premiums, you will be disenrolled.

In the case of a Special Separation, the employee continues to pay active employee premiums for an agreed upon time, as defined in the Special Separation Agreement. Coverage during the Special Separation period is administered by the Employee Service Center. You will receive a Special Separation form. The active employee premium rates are reflected on the Special Separation form and apply during the Special Separation period. The Special Separation period does not count as COBRA.

COBRA begins after the Special Separation period and may continue for 18 months. You will receive a Notification of Continuation of Coverage COBRA form from the Employee Service Center approximately two months prior to the end of the Special Separation period of coverage. The COBRA rates are listed on the COBRA form next to the appropriate Health Care plan and are valid at the end of the Special Separation period. Coverage during the COBRA period is administered by SHPS.

Eligibility

COBRA continuation coverage may be available to you and/or your dependent(s) if coverage was lost by becoming ineligible for medical or dental under the Procter & Gamble plans because of a qualifying event. However, if you and/or your dependent(s), become covered by Medicare or another group health plan after electing COBRA, the COBRA coverage will end.
If you, or your dependent(s), are covered by a group plan that has a pre-existing condition limitation that affects you, you may continue coverage under COBRA until the earlier of:

- the date the pre-existing limitation no longer affects you; or
- the date coverage would end according to the COBRA rules, whichever occurs first.

Eligible dependents covered at the time of the qualifying event have an independent right to COBRA, whether or not you are eligible to elect COBRA. A dependent that becomes eligible and enrolls during the COBRA continuation period does not have any independent rights to COBRA (including loss of eligibility during the continuation period).

How long COBRA may continue will depend on the qualifying event that made you or your dependent eligible for COBRA coverage.

**Claims**

Expenses which were applied to any deductible, out-of-pocket or annual maximum under your medical or dental plan carry over to COBRA coverage during the same plan year.

Under COBRA continuation coverage, there is no change in the way you file claims. Continue to file your claims with each claims administrator in the same way you always have. Claim forms may be obtained from your health care plan.

If your claim is denied, you should call the claims administrator of the individual plan to determine the reason. If you disagree, you may appeal.

**Appeals**

Your coverage under COBRA is a continuation of coverage you had under P&G-sponsored benefit plans. Therefore, you may appeal a denied or reduced claim by following the rules and procedures that pertain to each individual plan.
If you believe that your claim for benefits under COBRA continuing coverage has been unfairly denied or reduced, you should contact the Appeals Department for that Plan.

**Continue Group Health Plan Coverage**

Your continuing coverage in P&G plans, including COBRA continuation coverage, counts as creditable coverage for other employer plans. This may reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your new group health plan. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage. You should be provided a certificate of creditable coverage, free of charge, from P&G when you lose coverage either under the plan, or under COBRA continuation coverage.

**ERISA Rights**

As a participant in the UHC Base 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 and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, if applicable, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available from Public Disclosure at the Pension and Welfare Benefit Administration.

Obtain, upon written request to the plan administrator's office and at other specified locations, such as worksites and union hall, all documents governing the plan, including insurance contracts and collective bargaining, if applicable and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available from Public Disclosure at the Pension and Welfare Benefit Administration.
Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Exclusionary periods of coverage for preexisting conditions under your group health plan can be reduced or eliminated if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

**Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 the other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) benefit or exercising your rights under ERISA.

**Enforce Your Rights**

If your claim for a (pension, 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 case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file a suit in a state or Federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, 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, Room N-5625, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Future of Plans

Although we expect to continue the benefit Plans described in this document indefinitely, the Procter & Gamble Company, acting through its Board of Directors or Global Human Resources Officer, reserves the right to alter, amend or terminate any Plan. If the Board of Directors alters, amends or terminates the Plan, it shall be
through formal action either at a Board of Directors meeting or by written consent pursuant to state law. Alternatively, the Global Human Resources Officer may modify or terminate the Plan by signing a formal written statement of the alteration, amendment or termination.

If a Plan is terminated and isn't replaced by similar coverage, you'll be told of any conversion rights that may apply.

**HIPAA Privacy Notice**

*Effective 4/14/2003*

This Notice of privacy practices has been drafted to be consistent with what is known as the "HIPAA (the Health Insurance Portability and Accountability Act of 1996) Privacy Rule". We are required by law to provide you with this Notice and to comply with this Notice.

**Our Pledge Regarding Medical Information**

We understand that medical information about you and your health is personal. Protecting medical information about you is important. This notice applies to all of the records of your care generated under The Procter & Gamble Health Care Plans, whether made by health care professionals or other personnel.

This notice describes the type of information we might gather about you, with whom that information may be shared according to the HIPAA Privacy Rule and the safeguards we have in place to protect it. Generally, we receive only summary health information or information concerning plan enrollment or eligibility from the third party administrators or your insurance carriers. In addition, we may provide benefits through a health insurance issuer or health maintenance organization ("HMO"). The health insurance issuer or HMO may have its own policies and notice regarding your health information. You should review those notices for information about how the insurance issuer or HMO will handle your medical information in their possession.

You have the right to the confidentiality of your medical information and the right to approve or refuse the release of specific information except when the release is required by law. This notice will tell you about the ways in which we may use and
disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Maintain the privacy of your personal medical information;
- give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Who Will Follow This Notice

This notice describes The Procter & Gamble Health Care Plans' practices regarding the use of your medical information for treatment, payment or health care purposes described in this notice. All employees, staff and other personnel who may need access to your information follow the terms of this notice.

How We May Use and Disclose Medical Information About You, According to the HIPAA Privacy Rule

The following categories describe different ways that our health care plans (or the third party administrators or the insurance carriers) may use and disclose medical information. Not every use or disclosure in a category will be listed.

**For Treatment.** The health care professionals may use medical information about you to provide you with medical treatment or services. The medical information about you may be disclosed to doctors, nurses, technicians, training doctors, or other health care professionals who are involved in taking care of you. Different health care professionals also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays.

**For Payment.** We may use and disclose medical information about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. In addition, your
medical information may be used or disclosed to obtain prior approval or to
determine whether the treatment is covered under the Plan.

**For Health Care Operations.** We may use and disclose medical information
about you for health care quality control and benefit evaluation. This is
necessary to make sure that all of our participants receive quality care. For
example, we may use medical information to review and evaluate the services
you received. We may remove information that identifies you from this set of
medical information so others may use it to study health care and health care
delivery without learning who the specific persons are.

**Health-Related Benefits and Services.** We may use and disclose medical
information to tell you about health-related benefits or services that may be of
interest to you.

**As Required By Law.** We will disclose medical information about you when
required to do so by federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose
medical information about you when necessary to prevent a serious threat to
your health and safety or the health and safety of the public or another person.
Any disclosure, however, would only be to someone able to help prevent the
threat.

Special Situations, According to the HIPAA Privacy Rule

**Military and Veterans.** If you are a member of the armed forces, we may
release medical information about you as required by military command
authorities.

**Workers’ Compensation.** We may release medical information about you for
workers’ compensation or similar programs. These programs provide benefits
for work-related injuries or illness.

**Public Health Risks.** We may disclose medical information about you for
public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
to report births and deaths;

- to report child abuse or neglect;

- to report reactions to medications or problems with products;

- to notify people of recalls of products they may be using;

- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;

- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

**Health Oversight Activities.** We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** We may disclose medical information about you in response to a subpoena, discovery request, or other lawful order from a court.

**Law Enforcement.** We may release medical information if asked to do so by a law enforcement official as part of law enforcement activities; in investigations of criminal conduct or of victims of crime; in response to court orders; in emergency circumstances; or when required to do so by law.

**Coroners, Medical Examiners and Funeral Directors.** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.

**Your Rights Regarding Medical Information About You**

You have the following rights regarding medical information about you:
Right to Access. You have the right to review and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes.

You should directly contact the third party administrator or your insurance carrier hired by the Plans to request a copy or an inspection of your medical file. Your health care providers, not the Plan, maintain your medical information. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to your health care providers, the third party administrators or your insurance carrier. If you request a copy of the information, a fee may be charged for the costs of copying, mailing or other supplies associated with your request.

Your request to inspect and copy may be denied in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. The person conducting the review will not be the person who denied your request.

Right to Amend. If you feel that medical information about you is incorrect or incomplete, you may ask to amend the information. You have the right to request an amendment for as long as the information is kept.

To request an amendment, your request must be made in writing and submitted to the third party administrator or your insurance carrier listed in the Summary Plan Descriptions. In addition, you must provide a reason that supports your request.

Your request for an amendment may be denied if it is not in writing or does not include a reason to support the request. In addition, your request may be denied if you ask to amend information that:

- was not created by the Procter & Gamble Health Care Plans;
- is not part of the medical information kept by The Procter & Gamble Health Care Plans;
- is not part of the information which you would be permitted to inspect and copy; or
Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures" for instances in which we or our third party administrator disclosed your personal and health information for purposes other than treatment, payment, health care operation and certain other activities. To request this list or accounting of disclosures, you must submit your request in writing to our third party administrator or your health care providers. Your request must state a time period that may not be longer than six years and may not include dates before April 14, 2003. You may be charged for the costs of providing the list.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, you must make your request in writing to the third party administrator or your insurance carrier. In your request, you must state (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing. You must state that the information could endanger you if it is not communicated in confidence. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice at any time. To obtain a paper copy of this notice, please request one in writing from the Employee Service Center.

Changes To This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. The notice will contain on the first page, in the top right-hand corner, the effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Procter & Gamble Health Care Plan at:

HealthCare Benefits Managers
The Procter & Gamble Company
2 Procter & Gamble Plaza, TE-3, Box 4A
Cincinnati, OH 45202

If you are an active employee, you also may file a complaint with your immediate manager or the Human Resources contact for your site or organization. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We support your right to protect the privacy of your personal and health information.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information...
about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Privacy Officer

The Global Privacy Executive of the Procter & Gamble Company assumes the role of the HIPAA Privacy officer.

Contact Information:

To request a paper copy of this Privacy Notice, contact the Employee Service Center.

To contact your third party administrator or your insurance carrier, please refer to the Summary Plan Descriptions for that information. If you are an active employee, you may also refer to the Benefits Resources List, under "Find it Fast" of the Employee Resources section of my.PG.com.

HIPAA Privacy Rule Compliance

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Procter & Gamble Group Healthcare Plan ("Plan") may disclose Summary Health Information to the Plan Sponsor (The Procter & Gamble Company), if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

2. Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.536);

g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);

h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department on Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further use and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(ii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii), is established as follows:
i. The following employees, or classes for employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: Benefit Managers and staffs, Site benefit personnel, Plan Auditor and any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to, the Plan in the ordinary course of business.

ii. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

iii. In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further noncompliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment of health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-outs plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Disclosure of PHI to Obtain Stop-Loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator of the third party administrator or claims administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess

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loss coverage related to benefits claims under the Plan. Such disclosures shall be made in accordance with Privacy Standards.

5. Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with Privacy Standards.

Plan Identification

Official Plan Name:
The Procter & Gamble Health Care Plan

Plan Number:
503

Effective Date:
July 1, 1994

Plan Year:
Jan 1 thru Dec 31

Type of Plan:
Welfare Plan providing health care insurance for medical, dental, prescription medication, and organ transplant services

Type of Administration:
The Company shares responsibility with the insurance companies for administering these program benefits.

Contract Participants:
UnitedHealthcare
450 Columbus Blvd.
Hartford, CT 06103

UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
450 Columbus Blvd.
Hartford, CT 06103

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2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

The Procter & Gamble Company and its subsidiaries
EIN: 31-0411980

The Procter & Gamble Company Benefit Plan Trust
Two Procter & Gamble Plaza
Cincinnati, OH 45202

1.888.627.7472

Employer/Sponsor:
The Procter & Gamble Company and its subsidiaries
EIN# 31-0411980

The Procter & Gamble Company and its subsidiaries
Two Procter & Gamble Plaza
Cincinnati, Ohio 45202

Plan Trustees

BUSINESS ADDRESS OF EACH TRUSTEE

The address of all Trustees is:
Two Procter & Gamble Plaza, Cincinnati, Ohio 45202.

THE PROCTER & GAMBLE BENEFIT PLAN TRUST (HEALTH CARE PLANS)

D.A. Tiersch, Director, H.R. Finance, N.A.

J.G. Hagopian, Director, H.R. Product Supply, N.A.

J. P. Dierkes, Associate Director, Global Finance Employee Services

Plan Sponsor/Employer:
The Procter & Gamble Company and its subsidiaries
EIN: 31-0411980

The Procter & Gamble Company Benefit Plan Trust
Two Procter & Gamble Plaza
2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

Cincinnati, OH 45202
1.888.627.7472

Employer/Sponsor:
The Procter & Gamble Company and its subsidiaries
EIN# 31-0411980

The Procter & Gamble Company and its subsidiaries
Two Procter & Gamble Plaza
Cincinnati, Ohio 45202

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Glossary

Allogeneic

Sufficiently different from the recipient.

Assignment

Assignment is the transfer of a claim, right, interest or property from one person to another person.

In health care plans, for example, when you assign a benefit, you authorize the insurance company to pay the physician or hospital directly, instead of sending the benefit check to you.

For life insurance, when you assign a benefit, you transfer the right to make contributions, to obtain an individual policy or to change the beneficiary, to another person.

Autologous

Derived from the same individual.

Co-insurance

The term co-insurance refers to the percentage of covered expenses you are responsible to pay. For example, a co-insurance rate of 10% means that the Plan will pay 90% of covered expenses, and you are responsible for the remaining 10%. Plan-specific deductibles and out-of-pocket maximums may apply. Specific requirements may exist concerning deductibles and out-of-pocket maximums. Refer to the Benefit Amount (What’s Covered) section of the plan for information concerning how co-pay, deductibles and out-of-pocket maximums may impact co-insurance.

Covered Services/Charges

Covered services are those which are:
2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

- reasonable and customary, or based on the fee schedule allowance amount as determined by the plan; and
- performed or prescribed by a doctor;
- rendered to a covered person for the treatment of injury or sickness; and
- medically necessary in terms of generally accepted medical standards.

Deductible

Your deductible is a portion of covered medical expenses (for medical plans) or dental expenses (for dental plans) you pay before the Plan pays benefits.

Emergency Care

An emergency is a sudden, serious, unexpected, life-threatening illness or injury that requires immediate medical attention in a hospital emergency room. An emergency includes:

- accidental, traumatic bodily injury; and
- a serious life-threatening condition with severe symptoms which, if not immediately treated, could reasonably be expected to result in loss of life or permanent disability.

Some examples of conditions requiring emergency care are:

- severe bleeding;
- suspected heart attack;
- serious burns;
- severe stomach or chest pains;
- serious breathing difficulties;
- choking;
- poisoning;
- unconsciousness; and/or
- broken bones.

Evidence of Insurability
"Evidence of Insurability," sometimes referred to as "Evidence of Good Health" or "Proof of Good Health," means evidence acceptable to a plan's claims administrator that you are, or another applicant for coverage is, in good health.

Generally, evidence of insurability is provided in the form of a questionnaire about the applicant's medical history that must be completed to determine if enrollment in the plan will be approved. Providing evidence may also include a face-to-face assessment, telephone personal history interview and/or physical exam.

In most cases, when evidence of insurability is required, coverage will not take effect unless and until the evidence of insurability is approved by the claims administrator.

Contact the Employee Service Center for claims administration details.

**Experimental, Investigational or Unproven Care**

Experimental, Investigational or Unproven Services - medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, medication therapies or devices - that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- not approved by the U.S. Food and Drug Administration to be lawfully marketed for the proposed use and not identified in either the American Hospital Formulary Service, or the United States Pharmacopeia Dispensing Information, as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
Explanation of Benefits (EOB)

An Explanation of Benefits, or EOB, is a statement issued by a claims administrator notifying you of claims processed on your behalf, with an explanation of how charges were handled.

Extended/Skilled Nursing Care Facility

Extended/Skilled Nursing Care Facility is an institution or a distinct part of an institution that has a transfer agreement with one or more hospitals, and that is engaged in providing inpatient skilled nursing care and related services for patients who require medical or nursing care. The facility must:

- be accredited as an Extended or Skilled Nursing Care Facility by the Joint Commission on Accreditation of Hospitals, or is recognized as an Extended or Skilled Nursing Care Facility by Medicare;
- be supervised by one or more doctors and have one or more registered professional nurses responsible for the care of patients;
- have each patient under supervision of a physician;
- maintain clinical records on all patients;
- provide 24-hour nursing services;
- provide appropriate methods and procedures for the dispensing and administering of medications and biologicals;
- be duly licensed by the appropriate governmental authorities;
- not be, other than incidentally, a hotel, a motel, a place of rest, or place for custodial care, a facility for the aged or a facility for treatment of behavioral health diseases or substance abuse.

Notification/authorization may be required. Refer to your Plan's Coverage Information chart for details.

Full-Time
Regular employees are those persons employed by the Company on a full-time basis in continuing positions authorized by the appropriate Vice President. Full-time means the standard workweek (generally 40 hours) as established at each location. Employees do not include any persons whose services are provided under an agreement between the Company and a temporary employment agency or similar person or organization. The Company will determine if a person is a full-time employee.

Generic Medication

A generic medication is a prescribed medicine that is chemically equivalent and has the equal standards of safety, efficacy and quality with the FDA as name brand medications but is not trademarked. Generic medications are available for many commonly prescribed medicines, usually at significantly lower costs.

Medically Necessary/Medical Necessity

Health care services and supplies which are determined by the Plan administrator to be medically appropriate, and:

- necessary to meet the basic health or dental needs of the covered person;
- rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research, or health care and dental coverage organizations or governmental agencies that are accepted by the Company;
- consistent with the diagnosis of the condition;
- required for reasons other than the comfort or convenience of the covered person or his or her physician or dentist; and
- demonstrated through prevailing peer-reviewed medical or dental literature to be either:
  - safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - safe with promising efficacy for treating a life-threatening sickness or condition in a clinically controlled research setting, and using a specific
research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness or pregnancy does not mean that it is medically necessary as defined. This definition relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary.
Notification/Authorization

Notification/Authorization is the process of contacting the Plan to provide information that a covered person is seeking a particular treatment or hospital admission. Some plans require that you actually obtain their confirmation that a service, supply, medication or treatment is medically necessary. Other plans simply require you to inform them before the treatment or admission occurs in order to obtain coverage information and/or provide information needed to administer a claim.

Certain network-only plans rely on network providers to initiate the notification/authorization process. However, many plans hold the member responsible to contact the Plan for notification/authorization. Failure to follow the Plan's notification/authorization requirements may result in a substantial reduction in benefits as described in the Procedures > Notification/Authorization section of the Plan.

Out-of-Pocket Maximum for Prescription Medications

The out-of-pocket maximum for prescription medications is the most your family will have to pay for covered prescriptions within a calendar year. The out-of-pocket maximum is the total of all your coinsurance payments for eligible prescription medications.

Out-of-Pocket Maximum for Medical Expenses

An out-of-pocket maximum limits the amount of money you must pay each plan year for you or your family's share of covered expenses.

Once you or your dependents reach the out-of-pocket maximum, the Plan will pay 100% of most of the eligible, covered expenses for the rest of the plan year.

Not all of your out-of-pocket expenses are applied to the out-of-pocket maximum. In addition to the items listed on your Plan's Coverage Information chart, premiums paid for health care coverage, charges above eligible amounts and penalties for not obtaining notification/authorization are excluded from the out-of-pocket maximum. Further, any expenses the plan would not normally pay will continue to be your responsibility even after the out-of-pocket maximum has been reached.
Check your plan's Coverage Information Overview section to determine what is included in your out-of-pocket maximum.

**Primary Plan**

When a person is covered under more than one plan, the plan that is responsible for processing claims for that individual first is the primary plan.

The plan, if any, responsible for processing claims for that individual second, is called the secondary plan.

**Qualified Domestic Relations Order (QDRO)**

A Qualified Domestic Relations Order (QDRO), is an order or judgment from a state court directing the Plan Administrator to pay all or a portion of a participant's Plan benefits to a former spouse or dependent.

A QDRO may, for example, direct that all or part of your benefits under the Pension Plan or 401(k) Savings Plan be applied to:

- child support;
- alimony payments; or
- a marital property settlement agreement.

**Qualified Medical Child Support Order (QMCSO)**

A Qualified Medical Child Support Order (QMCSO) is a state court order, decree or judgment that requires group health plans to provide health benefits to a plan participant's child.

**Reasonable and Customary - Medical**

Generally, a reasonable and customary medical charge is the amount determined by the Plan to be appropriate reimbursement for a covered expense.

A covered expense is considered to be a "reasonable and customary charge" when it is within established fees for similar treatment or services, provided by a doctor with similar training, for specific medical conditions in a particular geographic area.
The term "reasonable and customary" also refers to the length of treatment and type of care the person receives for a diagnosed condition, and whether it is appropriate to established medical practices.

**Secondary Plan**

When a person is covered under more than one plan, the plan that is responsible for processing claims for that individual second is the secondary plan.

The plan responsible for processing claims for that individual first is called the primary plan.

**Subrogation**

A legal process whereby one party has the right to receive a refund from another party for medical claims paid.

An example of this would be injuries resulting from a traffic accident in which another party's automobile insurance is responsible for medical costs.

**Urgent Care**

An urgent care situation is an unexpected episode of illness or injury requiring treatment that cannot reasonably be postponed for scheduled physician care, but does not require emergency room care. Some examples are:

- abdominal pain;
- abrasions;
- acute sunburn;
- animal and insect bites;
- earache;
- fever below 104 degrees;
- minor burn;
- minor cut/laceration;
- persistent nausea and vomiting;
- significant flu;
- significant sore throat; and
- significant sprain.
2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

Contacts
COBRA Administrator - SHPS

Phone:
1.800.301.7559

Hours:
8:00 A.M. to 6:00 P.M. eastern time, Monday - Friday

Address:
SHPS
P.O. Box 34640
Louisville, KY 40232-4640
Attention: P&G COBRA Unit

Employee Service Center (ESC)

Phone:
1.888.627.7472

Fax:
1.513.983.1050

Hours:
8:00 A.M. to 6:00 P.M. Eastern time, Monday - Friday

External Address:
Procter & Gamble
Employee Service Center
P.O. Box 5511
Cincinnati, OH 45201-5511

Internal Address:
Costa Rica GBS
ESC - Bldg. A - 4th Floor

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2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

**Fiserv Health**

**Phone:**
1.800.337.5879

**Hours:**
9:00 A.M. to 5:00 P.M. eastern time, Monday - Friday

**Address:**
Fiserv Health
333 West Vine Street, Suite 500
Lexington, KY 40507-1627

**HIPAA Administrator**

**Phone:**
1.888.627.7472

**Fax:**
1.513.983.1050

**Hours:**
8:00 A.M. to 6:00 P.M. Eastern time, Monday - Friday

**External Address:**
Procter & Gamble
Employee Service Center
P.O. Box 5511
Cincinnati, OH 45201-5511

**Internal Address:**
Costa Rica GBS
ESC - Bldg. A - 4th Floor

**Healthcare Benefits Manager**

Healthcare Benefits Manager
The Procter & Gamble Company

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2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

2 Procter & Gamble Plaza, TE-3 Box 4A
Cincinnati, OH 45202

For Active Plans, mark the envelope: Attn: Active Employees
For Retiree Plans, mark the envelope: Attn: Retired Employees

UnitedHealthcare - Medical and Prescription Plan - Retiree

Phone:
1.800.638.9957 for:

- General Helpline (Select Option 1 for Prescriptions)
- Notifications/Authorizations

Hours:
8:00 A.M. to 5:30 P.M. eastern time, Monday - Friday

Website:
www.myuhc.com to obtain provider directory information.

www.uhcpharmacy.com

Claims Address - Medical:
UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800

Foreign Claims Address - Medical:
UnitedHealthcare
P.O. Box 740817
Atlanta, GA 30374

Appeals Address - Medical:
UnitedHealthcare Procter & Gamble Appeals Committee
P.O. Box 30432
Salt Lake City, UT 84130-0432

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2006 Summary Plan Description
UHC Base (Medical and Prescriptions)
Location: United States
Employee Status: Retiree/National Surviving Spouse

Claims Address - Prescriptions - Retail:
UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
P.O. Box 2096
Lee's Summit, MO 64063-7096

Appeals Address - Prescriptions - Retail:
UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
Procter & Gamble Appeals Committee
P.O. Box 30432
Salt Lake City, UT 84130-0432

Claims Address - Prescriptions - Home Delivery (not available with the Hospital/Surgical Plan):
UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
P.O. Box 747000
Cincinnati, OH 45274-7000

Appeals Address - Prescriptions - Home Delivery (not available with the Hospital/Surgical Plan):
UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
Procter & Gamble Appeals Committee
P.O. Box 30432
Salt Lake City, UT 84130-0432

Claims Address - Coordination of Benefits - Prescriptions:
UnitedHealthcare Pharmacy Network (administered by Medco Health Solutions, Inc.)
P.O. Box 2097
Lee's Summit, MO 64063-7097

Payor ID Number:
87726 (for claims processing)

Optum Nurseline:
1.800.805.8033

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