The Procter & Gamble Retiree Health Care Plan

Procter & Gamble offers retiree health care to employees who retire, their eligible dependents and surviving spouses. The plans are benchmarked against plans of a peer group of more than twenty Fortune 500 companies. This document advises you of:

- Eligibility
- Cost sharing
- Plans available and administered by UnitedHealthcare for Procter & Gamble
- Coverage under the plans

Eligibility to Participate in Retiree Health Care Coverage

When you retire, you are eligible for access to retiree health care if:

- You are a full-time employee when you retire
- You live in the United States (maintain permanent residency)
- You meet the Rule of 75 - Are at least age 55 with the sum of your age + years of service = 75 or more; or
  You are at least age 60 with ten (10) or more years of service.

Combined P&G and Gillette/Duracell years of service are used for determining eligibility for access to retiree health care.

A Gillette heritage employee who does not meet the P&G criteria above qualifies for retiree health care under Grandfathered Gillette retiree medical eligibility criteria if, **as of January 1, 2013**, the employee is at least:

-Age 50 with age & credited years of service equal to 80 points, or,
-Age 55 with 10 years of credited service, or
-Age 65 with 5 years of credited service

Cost for Retiree Health Care Coverage

- P&G retirees, spouses, and tax dependent domestic partners pay 20% of the cost of providing **medical coverage** (includes Rx); P&G child dependents, household dependents, and non-tax dependent domestic partners, and surviving spouses pay 100% of the cost. **Gillette heritage employees** who qualify for retiree health care (medical and dental) based on combined Gillette and P&G years of service maintain their Gillette legacy cost share percentage.

- **Gillette heritage employees** are in one of two groups:

  1. Employees who have Gillette/Duracell Company cost sharing benefits (Gillette Group 2's/Duracell Tier 1's & 2's) and retain those rights, or
  2. Employees who are Gillette Group 3's or Duracell Tier 3's who are responsible for 100% of the cost share.

  However, employees in both groups qualify for P&G cost share if they meet:

  1. P&G's Rule of 75 (at least age 55 with at least 20 P&G years of service only, or
  2. At least age 60 with at least 10 P&G years of service only.

- The total monthly premium is determined by adding the separate premium for each individual covered under the medical plan. (See chart on Page 2.)

- P&G retirees, spouses, child dependents, and tax dependent domestic partners pay 50% of the cost of **dental coverage** (single or family coverage). P&G household dependents, non-tax dependent domestic partners, and surviving spouses pay 100% of the cost. **Gillette heritage employees** who qualify for retiree health care (medical and dental) based on combined Gillette and P&G years of service maintain their Gillette legacy dental cost share of 100%.

- **Monthly retiree premiums** for July 1, 2009 through December 31, 2010 are:

Member/Cost Share %	Medical (under 65)	Medical (65 & over)	Dental
Monthly premium 100% Retiree/spouse/domestic partner (tax dependent) (each)***	$675.00	$250.00	Single: $29.80 Family: $59.60
P&G 20% Cost Share Retiree/spouse/domestic partner (tax dependent) (each)	$135.00	$50.00	P&G 50% Cost Share Single: $14.90 Family: $29.80
Child (each) 100%	$228.00	Eligible until age 25	Covered in Family
Household Dependent (each) 100%	$675.00	Eligible until age 65	$29.80
Domestic Partner (non-tax dependent) 100%	$675.00	$250.00	$29.80
Surviving Spouse 100%	$675.00	$250.00	$29.80

***** For a Gillette heritage employee who retains Gillette/Duracell cost share, the premiums depend on the cost share that the retiree is eligible for at retirement. Gillette heritage employees with a Group 2 or Duracell Tier 1 or 2 cost share multiply their cost share % by the full monthly retiree medical premium above (for retiree/spouse/domestic partner [tax dependent]) to determine their retiree medical premium. If you enroll Child(ren), a Household Dependent, or a Domestic Partner (non-tax dependent), you are responsible for 100% of the full premium per person; Gillette Group 2 or Duracell Tier 1 or 2 cost share does not apply when the Retiree Health Care plan offers access only to all retirees. A Gillette heritage employee who retains Gillette/Duracell cost share pays 100% of the dental premium**.

Spouse/Dependent Fee When Other Coverage Is Available: When your spouse or dependent (age 19 or over) has other medical coverage available at a cost of 50% or less of the cost of that plan; and he/she chooses not to take the single medical insurance offered as their primary plan, and you cover him/her under your P&G plan, you will be charged a monthly fee of $80 for each applicable person.

Retiree Health Care Plans

Plan Type	**Plans Available**	**Plan Description**
Medical: under 65	Preferred Provider Plan (PPO)	90/10: In Network 70/30: Out of Network
	Base Plan: Only for members living outside of network areas	80/20: No Network
Medical: 65 and over	Base Plan	80/20: No Network
Prescription Drug (Rx)	Same Rx plan included as part of all medical plans	70/30
Dental	CIGNA dental	Preferred Provider (PPO) or Fee schedule covers 50% of cost (approximately)

Enrollment for Retiree Health Care

- There is no annual open enrollment for retiree health care.
- Retirees must enroll to have retiree health care -- **THERE IS NO AUTOMATIC ENROLLMENT**. Retirees need to complete a Retiree Health Care Enrollment/Change/Waiver Form to either enroll in or to waive (defer) coverage. Contact the Employee Service Center (ESC) for assistance.
- Retirees and eligible dependents can enroll or drop medical and/or dental coverage at will and return to the retiree health care plans whenever desired and for whatever reason as long as the reenrollment criteria are met that are on the Retiree Health Care Enrollment/Change/Waiver Form. If a Group 2 retiree drops retiree medical coverage at any point during retirement, the retiree loses Group 2 status and will be required to pay 100% if he/she reenrolls in the P&G retiree medical plan in the future.
- After enrollment in a retiree health care plan, a third party administrator (UMR) mails a coupon booklet to retirees for the monthly premiums.

Surviving Spouse Benefits

Health care for surviving spouses of retirees, or active employees, who are retirement eligible on the date of their death, is identical to that for retirees with 3 exceptions:

- The retiree cost share is maintained for the first 12 months following the month of death after which time the plan costs (100%) are totally paid by the surviving spouse.
- Dependents of surviving spouses are not eligible for coverage.
- Customer service is provided by UMR.

Summary of Plan Coverage

- Pages 4-6 include a comparison chart between the PPO Plan (pre-Medicare plan) vs. the Base Plan (Medicare eligible Plan).

- Additional information, such as Retirement Policy and Retirement Checklist can be located at: ►my.PG.com►Life & Career►Life & Work Changes►Leaving P&G►Retirement

- Retiree Health Care Enrollment/Change/Waiver Form can be located at: ►my.PG.com►Life & Career►All Forms & Policies►All Forms►Benefit & Plans

- Plan Booklet for your retiree health care plan: the PPO Plan (pre-Medicare plan) and the Base Plan (Medicare eligible plan) can be downloaded by going to P&G's retiree website www.pg.com/champions under Benefits Forms.

Retiree Health Care: 2010 Preferred Provider Plan (PPO)vs. Base Plan			
Description	**Preferred Provider Plan In Network (INN) Effective 1-1-10 Under 65 Plan**	**Preferred Provider Plan Out-of–Network (OON) Effective 1-1-10 Under 65 Plan**	**Base Plan Effective 1-1-10 65 & Over Plan AND Under 65 Plan if not in a network area**
Deductible (Individual/Family)	None	$175/$350	$100/$200
Out of Pocket Maximum	$1,575/Individual or family. The following applies to in-network out-of-pocket maximum: *in-network co-pay (except behavioral health) *in-network co-insurance (except behavioral health and retail/home delivery prescription medications).	$3,150/Individual or family. The following applies to out-of-network out-of-pocket maximum: *out-of-network co-pay (except behavioral health and out-of-Organ Transplant Network-organ transplants) *out-of-network co-insurance (except behavioral health, out-of-Organ Transplant Network-organ transplants and retail/home delivery prescription medications) *out-of-network deductibles.	$1,575/Individual 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.
(Plan Pays/ Participant Pays)	90%/10%	70%/30%	80%/20%
PCP/Generalist (Family Practice, General Medicine, Internal Medicine, Pediatrician)	$15 co-pay/office visit only; then Plan pays 90% of all other eligible expenses.	Plan pays 70% of eligible expenses after deductible.	Plan pays 80% of eligible expenses after deductible
Specialist	$25 co-pay/office visit only; then Plan pays 90% of all other eligible expenses.	Plan pays 70% of eligible expenses after deductible.	Plan pays 80% of eligible expenses after deductible
Hospital Facility	**Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid.** 100% of covered charges after $250 inpatient hospitalization co-pay for services billed by the facility. 90% of covered charges for services billed separately.	**Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid.** 70% of covered charges after annual deductible.	**Pre-certification required. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid.** 80% of covered charges after annual deductible.
Outpatient Surgery Facility	100% of covered charges after $150 outpatient hospitalization co-pay for services billed by the facility. 90% of covered charges for services billed separately.	70% of covered charges after annual deductible.	80% of covered charges after annual deductible.
Emergency Room	$100 co-pay/visit; waived if admitted.	$100 co-pay/visit; waived if admitted.	Plan pays 80% of eligible expenses/visit after deductible
In-Patient Physician Visits	Plan pays 90% of eligible expenses.	Plan pays 70% of eligible expenses after deductible.	Plan pays 80% of eligible expenses after deductible

Description	Preferred Provider Plan In Network (INN) Effective 1-1-10 Under 65 Plan	Preferred Provider Plan Out-of–Network (OON) Effective 1-1-10 Under 65 Plan	Base Plan Effective 1-1-10 65 & Over Plan AND Under 65 Plan if not in a network area
Out patient Laboratory & X-ray	Plan pays 90% of eligible expenses.	Plan pays 70% of eligible expenses after deductible.	Plan pays 80% of eligible expenses after deductible
Home Health Care	Plan pays 90% of eligible expenses.	Plan pays 70% of eligible expenses after deductible.	Plan pays 80% of eligible expenses after deductible
Chiropractic Care	100% of covered charges after generalist co-pay; then Plan pays 90% of other eligible expenses. 20 visits/year/person limit (INN and OON combined).	Plan pays 70% of eligible expenses after deductible. 20 visits/year/person limit (INN and OON combined).	Plan pays 80% of eligible expenses after deductible. 20 visits/year/person limit
Therapy – Occupational, Physical or Speech	100% of covered charges after generalist co-pay for office visits only. 90% of other covered charges. **Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization**.	70% of covered charges after annual deductible. **Maximum: 60 visit limit per person per plan year (in-network and out-of-network combined). Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization**.	80% of covered charges after annual deductible. **Maximum: 60 visit limit per person per plan year. Limit applies to any combination of occupational, physical or speech therapy administered under all circumstances, whether performed in an office, home care or hospice setting, except as part of inpatient hospitalization.**
Organ Transplants-Hospital Care Inpatient	**Pre-certification required for all services related to organ transplants. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid**. 100% of covered charges after inpatient hospitalization co-pay for services billed by hospital. 90% of covered charges for services billed separately. Includes: Bone Marrow - Allogenic, Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. **Any transplant not listed above but required by law.**	**Pre-certification required for all services related to organ transplants. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid**. 70% of covered charges after annual deductible. Includes: Bone Marrow - Allogenic, Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. **Any transplant not listed above but required by law.**	**Pre-certification required for all services related to organ transplants. After initial pre-certification, if number of certified hospital days are extended without additional certification, no benefits will be paid**. 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. Includes: Bone Marrow - Allogenic, Autologous for certain diagnosis, Heart, Heart-Lung, Kidney, Liver, Lung, Multivisceral, Pancreas, Pancreas-Kidney, Small Bowel. **Any transplant not listed above but required by law.**
Orthotics	90%/10%, max 1 pair per person/CYr for shoes worn most often	70%/30%, max 1 pair per person/CY for shoes worn most often	Plan pays 80% of eligible expenses after deductible

Description	Preferred Provider Plan In Network (INN) Effective 1-1-10 Under 65 Plan	Preferred Provider Plan Out-of–Network (OON) Effective 1-1-10 Under 65 Plan	Description
Durable Medical Equipment	90% of covered charges. Includes approved repairs & replacements.	70% of covered charges after annual deductible. Includes approved repairs & replacements.	80% of covered charges after annual deductible. Includes approved repairs & replacements.
Mental Health Services	**Pre-certification required via UBH.** 100% of covered charges after $250 inpatient hospitalization co-pay for services billed by facility. 90% of covered charges for services billed separately. (For more details, refer to the SPD)	**Pre-certification required via UBH.** 70% of covered charges. No deductible applied for behavioral health services. (For more details, refer to the SPD)	**Pre-certification required via UBH.** 80% of covered charges. No deductible applied for behavioral health services. (For more details, refer to the SPD)
Prescription Drug Coinsurance (Plan/Participant)	70%/30% Up to 120 days supply	70%/30% Up to 120 days supply	70%/30% Up to 120 days supply
Prescription Drug Out-of-Pocket Maximum	$1,500/person or family/year	$1,500/person or family/year	1,500/person or family/year
Medical Premiums: Pre-Medicare (20% cost share):	Retiree/Spouse: $135.00/mo	Retiree/Spouse: $135.00/mo	Retiree/Spouse: $135.00/mo
Medical Premiums: Pre-Medicare (100% cost share):	Retiree/Spouse: $675.00/mo	Retiree/Spouse: $675.00/mo	Retiree/Spouse: $675.00/mo
Medical Premiums: Medicare (20% cost share)	Retiree/Spouse: $50.00/mo	Retiree/Spouse: $50.00/mo	Retiree/Spouse: $50.00/mo
Medical Premiums: Medicare (100% cost share)	Retiree/Spouse: $250.00/mo	Retiree/Spouse: $250.00/mo	Retiree/Spouse: $250.00/mo
Medical Premiums:	Child: $228.00/mo	Child: $228.00/mo	Child: $228.00/mo
Dental Premiums:	Retiree: $14.90/mo	Retiree: $14.90/mo	Retiree: $14.90/mo
	Family: $29.80/mo	Family: $29.80/mo	Family: $29.80/mo

Notes:

- The pre-Medicare plan a retiree is enrolled in is determined by the zip code of legal residence. Retirees do not have a choice of plans and there is no annual open enrollment. If the retiree lives in an area with a network, the pre-Medicare retiree or dependent is enrolled in the PPO plan; otherwise, the Base plan. Call the ESC (1-888-627-7472) to determine if your zip code is in the PPO.
- When the retiree/dependent is Medicare eligible, he/she is enrolled in the Base plan automatically.
- Premiums for both pre-Medicare plans are the same. Upon becoming Medicare eligible, premiums are reduced since Medicare is primary.