Important Notice

This Summary Plan Description (SPD) booklet, including any subsequent related Summaries of Material Modifications (SMMs), is intended to help you understand the main features of the Retiree Medical Program of The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Benefits Plan applicable to former Employees of Prudential and its Affiliates who have separated from service on or after January 1, 2001, with entitlement to immediate or future benefits under the Retiree Medical Program described and to provide information regarding your benefits. It is not intended to address any person with a current employment relationship with Prudential or its Affiliates, whose benefits may vary from those described, and whose benefits are described in other SPD booklets.

This SPD booklet, including any subsequent related SMMs, together with the HMO Appendix booklet constitutes the latest SPD booklet of the Retiree Medical Program of The Prudential Welfare Benefits Plan through March 30, 2014, and of The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Plan also cover other classes of Employees and Retirees as described in other SPD booklets that cover those specific Employee and Retiree populations.

The Prudential Retiree Welfare Benefits Plan was established by the Company effective January 1, 2014, to provide various retiree health and welfare benefits previously provided by The Prudential Welfare Benefits Plan. Specifically, Retiree Medical Program benefits are provided under The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All references to The Prudential Welfare Benefits Plan in this SPD booklet should be read to refer to The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All other terms, conditions, limitations and exclusions of this SPD booklet are hereby incorporated and form the Summary Plan Description for The Prudential Retiree Welfare Benefits Plan.

This SPD booklet, including any subsequent related SMMs, is not a substitute for the official Plan Document(s) which governs the operation of the Retiree Medical Program. All terms and conditions of the Retiree Medical Program, including your eligibility and any benefits, will be determined pursuant to and are governed by the provisions of the applicable Plan Document(s). If there is any discrepancy between the information in this SPD booklet, including any subsequent related SMMs, or in any other Prudential materials relating to the Retiree Medical Program and the actual Plan Document(s), or if there is a conflict between information discussed by anyone acting on Prudential’s behalf and the actual Plan Document(s), the Plan Document(s), as interpreted by the applicable Plan Administrator in its sole discretion will always govern.

Prudential may, in its sole discretion, modify, amend, suspend or terminate any and all of its HR policies, programs, Plans and benefits, including those described in this SPD booklet, including any subsequent related SMMs, in whole or in part, at any time, without notice to or consent of any participant, employee or former employee to the extent permissible under applicable law.

Enrollment and Election Changes

The Prudential Benefits Center website at www.prubenefitscenter.com is your primary resource to enroll for coverage or make changes to your elections. When you process your enrollment through the Prudential Benefits Center website, you will look there to find the instructions and guidance you will need for completing the process and confirming your enrollment or changes. If you do not have access to a computer or the Internet, if you wish to make any changes to your elections due to a Qualified Change in Status, change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member, enroll for coverage if you are a Retiree who initially declined coverage at retirement, or if you have any questions as to whether you are properly completing your transaction, call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits. Prudential Benefits Center Representatives are available to assist you between 8 a.m. and 6 p.m., Eastern time, Monday through Friday, except on holidays. For the hearing-impaired, please contact your local relay service.
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How to Contact the Prudential Benefits Center

Throughout this Summary Plan Description (SPD) booklet, you will see references to the Prudential Benefits Center, which is your primary resource for information about most of your Prudential benefits. You can reach the Prudential Benefits Center online, by telephone or by mail.

Online Access

Through the Prudential Benefits Center website, you can:

- Access benefits forms you may need;
- Get information on how to contact insurers and service providers; and
- Find links to carrier websites and online provider directories.

The Prudential Benefits Center website is available via the Internet. Log on to www.prubenefitscenter.com to access the Prudential Benefits Center website 24 hours a day, 7 days a week.

You can also use the online chat feature on the Prudential Benefits Center website to get in touch with a Prudential Benefits Center Representative who can answer your questions about navigating the site or general questions about your benefits. From the home page on the Prudential Benefits Center website, click the “Web Chat” icon. Prudential Benefits Center Representatives are available between 8 a.m. and 6 p.m., Eastern time, Monday through Friday, except on holidays.

If you do not have a computer or Internet access, follow the instructions below for contacting the Prudential Benefits Center by telephone or by mail.

Viewing This SPD Booklet Online

This SPD booklet has been designed for ease of use when viewing it online. It includes many navigation features that allow you to locate the information you need and to access it quickly.

Telephone Access

You may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits. Prudential Benefits Center Representatives are available to assist you between 8 a.m. and 6 p.m., Eastern time, Monday through Friday, except on holidays. For the hearing-impaired, please contact your local relay service.

Mail Access

The mailing address for filing claims related to program enrollment and eligibility is:

Prudential Benefits Center
Claims and Appeals Management (CAM)
P.O. Box 1407
Lincolnshire, IL 60069-1407

Terms and Conditions

When you use the Prudential Benefits Center website (at www.prubenefitscenter.com), you are agreeing to use it under the terms and conditions prescribed by the Company. These terms and conditions are maintained on the Prudential Benefits Center website for easy reference. Or, to obtain a copy, call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.
Introduction to the Retiree Medical Program

Throughout this SPD booklet, you will see terms whose first letters are capitalized. When you see these terms, you can check the Glossary at the back for detailed definitions and how the definitions apply to the benefits described in the SPD booklet.

Good health is important at any age—and so are good medical benefits. Prudential provides you and your family with a program of medical benefits that helps you get the services you need when you are sick, as well as the routine care that helps you stay well. Through the Prudential Retiree Medical Program, you and your Qualified Dependents can take advantage of benefits and programs that contribute to your good health—and save you money. The Retiree Medical Program is governed by the terms of The Prudential Welfare Benefits Plan through March 30, 2014, and The Prudential Retiree Welfare Benefits Plan effective March 31, 2014.

The Prudential Retiree Welfare Benefits Plan was established by the Company effective January 1, 2014, to provide various retiree health and welfare benefits previously provided by The Prudential Welfare Benefits Plan. Specifically, Retiree Medical Program benefits are provided under The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All references to The Prudential Welfare Benefits Plan in this SPD booklet should be read to refer to The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All other terms, conditions, limitations and exclusions of this SPD booklet are hereby incorporated and form the Summary Plan Description for The Prudential Retiree Welfare Benefits Plan.

About the Retiree Medical Programs Described in This Summary Plan Description Booklet

This Retiree Medical Program Summary Plan Description (SPD) booklet describes the variety of Retiree Medical Program options Prudential offers to its Retirees, Long Term Disability participants and Surviving Dependents with a Benefits Eligibility Date on or after January 1, 2001. The programs available to you depend on your Medicare eligibility and, in some cases, where you live.

If you are not Medicare-eligible, you and your Qualified Dependents may be eligible for the following Retiree Medical Programs:

- Retiree Medical Program E – High Deductible Health Program (HDHP);
- Retiree Medical Program E – Consumer Directed Health Program 80 (CDHP 80);
- Retiree Medical Program E – Consumer Directed Health Program 90 (CDHP 90);
- Health Maintenance Organizations (HMOs); and
- Retiree Medical Program E – Indemnity (for residents of Hawaii only).

If you are Medicare-eligible, you and your Qualified Dependents may be eligible for the following Retiree Medical Programs:

- Retiree Medical Program E – Indemnity;
- Medicare Advantage Programs; and
- Medicare Cost Program.

Retiree Medical Program E – High Deductible Health Program

Retiree Medical Program E – High Deductible Health Program (HDHP), administered by Cigna, is available in all locations (except Hawaii). The HDHP features a comparatively high annual Deductible,

The HDHP, CDHP 80 and CDHP 90 medical programs administered by Cigna HealthCare are Cigna’s “Open Access Plus” program, but herein will be referred to as the HDHP, CDHP 80 and CDHP 90.
which must be satisfied before the Program provides most benefits, both In-Network and Out-of-Network. The HDHP includes In-Network and Out-of-Network benefits. Retirees who enroll in the HDHP may elect to contribute to a Health Savings Account (HSA) to fund qualified health care expenses. The HDHP is available to Retirees, Long Term Disability participants and Surviving Dependents who are not Medicare-eligible.

Retiree Medical Program E – Consumer Directed Health Program 80 and Retiree Medical Program E – Consumer Directed Health Program 90

Retiree Medical Program E – Consumer Directed Health Program 80 (CDHP 80) and Retiree Medical Program E – Consumer Directed Health Program 90 (CDHP 90) are administered by Cigna and are available in all locations (except Hawaii). Both the CDHP 80 and the CDHP 90 feature In-Network and Out-of-Network benefits. You have the choice of using Participating Providers and receiving a higher level of benefits, or using doctors outside the network and receiving a lower level of benefits. Both programs offer the same covered health care services, but the CDHP 80 has lower monthly contributions for coverage and higher potential out-of-pocket costs (such as the annual Deductible and Coinsurance) than the CDHP 90. If you enroll in the CDHP 80 or the CDHP 90, Prudential provides you with a Health Fund to help pay for your current health care expenses. The CDHP 80 and CDHP 90 are available to Retirees, Long Term Disability participants and Surviving Dependents who are not Medicare-eligible.

Health Maintenance Organizations

One Health Maintenance Organization (HMO), administered by Aetna, is offered on a national basis in all locations where Aetna has a network. In addition, a number of local HMOs are offered. The HMOs offer In-Network benefits if you live in an area where the HMO has an established network of Participating Providers. There are no benefits payable for services rendered by non-Participating Providers (other than treatment for Emergency care). The HMOs are available to Retirees, Long Term Disability participants and Surviving Dependents who are not Medicare-eligible.

Retiree Medical Program E – Indemnity

Retiree Medical Program E – Indemnity is a traditional Indemnity program administered by Cigna. Under the Retiree Medical Program E – Indemnity, you can visit any doctor or health care provider. For most services, you will pay for your care up to an annual Deductible amount. Then, you and the Program share the expenses of covered medical care and services. For Preventive Care services, the annual Deductible is waived. Retiree Medical Program E – Indemnity is available to Retirees, Long Term Disability participants and Surviving Dependents who are Medicare-eligible, regardless of where they live. Retiree Medical Program E – Indemnity is also available to Retirees, Long Term Disability participants and Surviving Dependents who are not Medicare-eligible and reside in Hawaii.

Medicare Advantage Programs

Medicare Advantage Programs are available for participants who are eligible for Medicare and their Dependents who are eligible for Medicare. (Where available, non-Medicare-eligible Dependents of Medicare-eligible participants may also be covered under the corresponding “companion” coverage option.) With a Medicare Advantage Program, you pay a monthly contribution (if required) and the Program provides you with comprehensive medical coverage—including Prescription Drug benefits. A Medicare Advantage Program replaces the benefits provided under Medicare Part A (Hospital insurance), Part B (medical insurance) and Part D (Prescription Drug insurance). However, if you enroll in a Medicare Advantage Program, you must enroll in Medicare Part A and enroll in and pay premiums for Medicare Part B (and Part D, if applicable). You and your Medicare-eligible dependents must also complete an enrollment form, available from the Prudential Benefits Center, in order for your enrollment to take effect.

2 The HDHP, CDHP 80 and CDHP 90 medical programs administered by Cigna HealthCare are Cigna’s “Open Access Plus” program, but herein will be referred to as the HDHP, CDHP 80 and CDHP 90.

3 The HMO administered by Aetna is called Aetna Select, but herein will be referred to as an HMO.
Information about the companion coverage available through the applicable Medicare Advantage Program carriers is included in this SPD booklet. See the “Companion Coverage” section beginning on page 168.

**Medicare Cost Program**

The Medicare Cost Program is available in Minnesota and select counties in Wisconsin for participants who are eligible for Medicare and their Dependents who are eligible for Medicare. (Non-Medicare-eligible Dependents of Medicare-eligible participants may also be covered under “companion” coverage.)

The Medicare Cost Program is similar to Medicare Advantage Programs in many ways. The program includes benefits covered under Medicare Part A (Hospital insurance), Part B (medical insurance) and Part D (Prescription Drug insurance). In addition, the Medicare Cost Program provides the flexibility to receive care Out-of-Network (since Medicare benefits will still apply). This means participants won’t need a referral when seeing a Specialist.

If you enroll in the Medicare Cost Program, you must enroll in Medicare Part A and enroll in and pay premiums for Medicare Part B (and Part D, if applicable). You and your Medicare-eligible dependents must also complete an enrollment form, available from the Prudential Benefits Center, in order for your enrollment to take effect.

Information about the companion coverage available through the Medicare Cost Program is included in this SPD booklet. See the “Companion Coverage” section beginning on page 168.

**For More Information**

For information about the programs available to you, see the Annual Enrollment materials provided during the Annual Enrollment Period or contact the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

**When You Need Help**

Here are the resources to contact when you need help or information:

- For answers to general questions about your benefits (such as eligibility for coverage or the Cost of coverage), visit the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)). If you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits;

- For answers to questions about specific Retiree Medical Program provisions (such as what types of expenses are covered), to obtain provider information or for help with Precertification, call the health care carrier’s member services telephone number:

  — Cigna HealthCare member services (HDHP, CDHP 80, CDHP 90 and Retiree Medical Program E – Indemnity):
    Telephone: 1-888-502-4462
    Website: [www.cigna.com/prudential](http://www.cigna.com/prudential)

  — Aetna member services (Aetna HMO):
    Telephone: 1-877-542-0726
    Website: [www.aetna.com/docfind/custom/pruretiree](http://www.aetna.com/docfind/custom/pruretiree)

  — Medicare Advantage Program, Medicare Cost Program or an HMO other than the Aetna HMO: Call the member services department of your Medicare Advantage Program, Medicare Cost Program or local HMO. Member services telephone numbers for the Medicare Advantage Programs, the Medicare Cost Program and local HMOs can be found on your identification card and are also available on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com));
• For answers to questions about filing claims or for help with a specific claim, call the health care carrier’s member services telephone number. You will find this number on your identification card and on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)). If you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and follow the prompts for Health and Welfare benefits; or

• For answers to questions about the Retiree Medical Savings Account (RMSA) and receiving reimbursement through the RMSA for eligible premiums, call UnitedHealthcare at 1-866-278-0771 between 8 a.m. and 8 p.m., Eastern time, Monday through Friday, except on holidays.

**Please note:** If you are enrolled in a Medicare Advantage Program, the Medicare Cost Program or an HMO other than the Aetna HMO, you will need to call the member services department of your Medicare Advantage Program, Medicare Cost Program or HMO for specific program information. Member services telephone numbers for the Medicare Advantage Programs, the Medicare Cost Program and HMOs can be found on your identification card and are also available on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)).
Prudential’s Financial Support for Retiree Health Care Coverage Costs

The Credit Approach and the Retiree Medical Savings Account (RMSA) represent different ways Prudential may provide financial support to you for Retiree health care coverage after you Retire.

If you are eligible for Retiree Medical Program coverage and:

- **Retire on or after January 1, 2011,** you will receive the RMSA for financial support for Retiree health care coverage;

- **Retired on or after January 1, 2008, and prior to January 1, 2011,** you were eligible to make a one-time irrevocable choice at retirement to elect either the Credit Approach or the RMSA. If you did not make an election for financial support for Retiree health coverage, you defaulted to the RMSA; or

- **Retired prior to January 1, 2008,** you have the Credit Approach for financial support for retiree health care coverage.

Please refer to the *Financial Support for Your Retiree Health Care: Planning for Your Future* brochure, the *RMSA Resources Guide* for a more detailed description of the RMSA. These resources are available on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)). If you would like to request a printed copy of these resources, you may do so by calling the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and following the prompts for Health and Welfare benefits. The *RMSA Resources Guide* is also available on the UnitedHealthcare website (at [www.uhealthaccounts.com](http://www.uhealthaccounts.com)).

**Please note:** Whether you have the Credit Approach or the RMSA, you can also choose not to enroll in Prudential-sponsored Retiree medical coverage immediately upon retirement and you will have one opportunity to elect such coverage at a later date. However:

- If you initially defer coverage, later choose to enroll in Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time; or

- If you initially enroll for Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time.

The Company reserves the right to modify or terminate any of its policies, procedures, plans and programs, or benefits at any time, to the extent it is permissible under applicable law, including the Retiree medical credit under the Credit Approach and RMSA allocations. Effective January 1, 2014, the RMSA is governed under the terms of The Prudential Retiree Welfare Benefits Plan.

**The Credit Approach**

**How the Credit Approach Works**

Effective January 1, 2001, Prudential limited its future financial commitment to Retiree medical benefits by introducing the Credit Approach. Under the Credit Approach, Prudential placed a “cap” on its future annual financial commitment toward the cost of Retiree medical premiums for all Retirees who retired on or after January 1, 2001, and prior to January 1, 2011. Employees who Retired in 2008, 2009 and 2010 had a one-time irrevocable choice between the Credit Approach and the RMSA. The Credit Approach is not available to Employees who Retire on or after January 1, 2011.

Prudential will contribute toward the Cost of your Retiree Medical Program coverage in the form of a fixed credit (that is, it will not increase in future years). Your credit amount depends on your years of continuous service at retirement, whether you and/or your covered Spouse or Qualified Adult is eligible for Medicare and how many Qualified Dependents you cover. The only time the credit that
applies to you or your Spouse or Domestic Partner will change is when you or your Spouse or Domestic Partner becomes eligible for Medicare. The amount you pay for coverage each Calendar Year (your contribution) will be the total Cost, or premium, for the Prudential-sponsored Retiree Medical Program you select, minus the amount of the applicable credit provided by Prudential. The contribution will be determined separately for you, your covered Spouse or Qualified Adult and your covered Dependent Children. If your or your Dependents’ annual credit is more than your or your Dependents’ Cost for the Retiree Medical Program that you are enrolled in:

- You will have no contribution for yourself or that covered Dependent but you will not receive the remaining balance;
- That amount cannot be used to offset the Cost for you or a covered Dependent; and
- It cannot be carried over to subsequent Calendar Years.

### Highlights of the Credit Approach

<table>
<thead>
<tr>
<th>Highlights of the Credit Approach</th>
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<tbody>
<tr>
<td><strong>Health Care Options and Coverage</strong></td>
</tr>
<tr>
<td>In order to receive the annual credit from Prudential, you must enroll in Prudential-sponsored Retiree medical coverage;</td>
</tr>
<tr>
<td>The credit may not be used to offset the cost of Retiree dental or Retiree vision coverage*;</td>
</tr>
<tr>
<td>You will only receive credits for Dependents to the extent that they are covered under Prudential-sponsored Retiree medical coverage; and</td>
</tr>
<tr>
<td>You cannot apply the credit to COBRA coverage upon your retirement.</td>
</tr>
<tr>
<td><strong>Whom You Can Cover</strong></td>
</tr>
<tr>
<td>You will receive an annual credit for any individual who is covered under the Prudential-sponsored Retiree Medical Program. Generally, you can cover a Spouse or Qualified Adult (Domestic Partner or Extended Family Member), as well as any eligible Dependent Children. If you cover Dependent Child(ren), you will receive the same credit amount regardless of the number of children you cover; and</td>
</tr>
<tr>
<td>If you elect to cover a Domestic Partner, Imputed Income may apply to Prudential’s portion of the cost of the coverage for your Domestic Partner.</td>
</tr>
<tr>
<td><strong>Payments</strong></td>
</tr>
<tr>
<td>The credit applicable to you and your situation will be deducted from the annual cost of coverage (premium) you select. The remainder will be withheld from your pension check if it is sufficient. Otherwise, you will be billed directly; and</td>
</tr>
<tr>
<td>You will continue to receive annual credits as long as you are enrolled in the Prudential-sponsored Retiree Medical Program.</td>
</tr>
<tr>
<td><strong>If You Are Enrolled in the Prudential Consumer Directed Health Program 80 or Consumer Directed Health Program 90</strong></td>
</tr>
<tr>
<td>If you are enrolled in a Prudential Consumer Directed Health Program (CDHP) option and continue in a CDHP option as a Retiree (Retiree Medical Program E – CDHP 80 or Retiree Medical Program E – CDHP 90), the amount in your Health Fund will continue to be available for claims under a CDHP option;</td>
</tr>
<tr>
<td>If you are enrolled in a CDHP option and your annual Health Fund exceeds the limit of $800 for individual coverage or $1,600 if you are covering yourself and others, the excess amount will be forfeited; and</td>
</tr>
<tr>
<td>If you do not remain enrolled in a CDHP option at retirement or disenroll for any reason in the future (including becoming eligible for Medicare), you will lose any existing balance in the Health Fund.</td>
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</table>

Table and footnote continue on page 8
COBRA

- Generally, under the Credit Approach, enrolling in the Prudential Retiree Medical Program is less expensive than COBRA continuation coverage available when you retire. However, since retirement is a COBRA Qualifying Event, Prudential is required to offer the opportunity for COBRA continuation coverage under the coverage in which you were enrolled as an active Employee. If you choose COBRA continuation coverage, you will pay 102% of the full coverage cost and coverage will generally continue for a maximum of up to 18 months. You will not receive the annual credit while you are enrolled for COBRA coverage.

*Prudential-sponsored Retiree dental coverage (Dental Preferred Provider Organization or Dental Health Maintenance Organization) may be purchased at full cost by Retirees under age 65. There is also a Prudential-sponsored Retiree Dental Discount Program, a Vision Care Insurance Program and a Vision Discount Program available for all Retirees, regardless of age. Please note: The credit cannot be applied to the premiums for any of these coverages.*

The Retiree Medical Savings Account (RMSA)

How the RMSA Works

The RMSA is a recordkeeping account you can use after retirement to be reimbursed for the cost of premiums for certain Retiree medical, dental, vision and Prescription Drug coverage. Employees who retired on or after January 1, 2008, and prior to January 1, 2011, were eligible to make a one-time irrevocable choice at retirement to elect either the Credit Approach or the RMSA. Retirees who retire on or after January 1, 2011, will receive the RMSA for financial support for Retiree health care coverage.

The RMSA provides flexibility since you can use your RMSA to pay for:

- Premiums for Prudential-sponsored Retiree medical, dental and vision programs for you and your eligible Dependents;
- COBRA premiums for Prudential-sponsored medical, dental or vision coverage for you and your eligible Dependents immediately after your retirement;
- Premiums for non-Prudential-sponsored medical, dental, vision and Prescription Drug programs that you have obtained as an individual for yourself and your Dependents including coverage obtained through your state’s Health Insurance Marketplace (also referred to as “Exchanges”) and individual discount-only medical, dental and vision coverage. Please note: Premiums for other employer-sponsored programs, such as coverage you may be eligible for through a Spouse or Domestic Partner’s employer or coverage you may be eligible for from a prior or current/prospective employer are not reimbursable from the RMSA; and
- Premiums for Medicare Parts B and/or D, as well as for Medicare Advantage Plans (also known as Medicare Part C), for you and your Dependents after you become eligible for Medicare.

The RMSA cannot be used for any out-of-pocket expenses you may incur when obtaining health care services, such as Copays, Coinsurance or annual Deductibles.

If you were eligible for active Employee medical coverage as of December 31, 2007, an RMSA was established for you. This notional account received an initial allocation, or an RMSA opening account balance, equal to your number of years of continuous service at Prudential multiplied by the initial allocation rate of $2,100.

The RMSA can grow in a number of ways during an Employee’s working years and after retirement. During employment with Prudential after December 31, 2007, you received a monthly allocation to your RMSA. You were eligible for a monthly allocation if you were age 40 or older and eligible for active Employee medical coverage. The monthly allocation was based on your job grade. If you were enrolled in a Prudential Consumer Directed Health Program (CDHP) option during your employment, you may have also received an allocation to your RMSA as a result of transfer from the Health Fund.
Your RMSA continues to grow at and after retirement in four ways:

- If, at retirement, you are eligible for Retiree medical benefits and you have a Spouse or Domestic Partner (same- or opposite-sex), you will receive an additional one-time allocation equal to 50% of your RMSA balance at that time. Please note that your Domestic Partner must be eligible for Prudential-sponsored Retiree medical coverage at the time of your retirement for this amount to be added to your RMSA balance. To receive your one-time allocation, you must certify on the Prudential Benefits Center website (at www.prubenefitscenter.com) that you are married or have an eligible Domestic Partner;

- After retirement, your account will be credited with interest on the last day of each month. The annual interest rate will be 5%, credited on a monthly compound basis, based on your RMSA balance on the last day of each month;

- If you are enrolled in a Prudential Consumer Directed Health Program (CDHP) option and your annual Health Fund exceeds $800 for individual coverage or $1,600 if you are covering yourself and others, the excess amount will be transferred to your RMSA on or after April 30 of the new program year; and

- If you are enrolled in a Prudential CDHP option and you disenroll after you Retire for any reason, any amount in your Health Fund will automatically transfer to your RMSA after 120 days. If you do disenroll, keep in mind that claims submitted to a CDHP option after 120 days will be paid according to the CDHP option as if the Health Fund were depleted.

Please note: Your RMSA is a notional account. This means that although the funds are available to you for reimbursement, you cannot cash out, roll over or receive amounts from this account in any other way except for reimbursement of submitted premium receipts for the cost of eligible health care programs. Also, please note that you cannot make contributions to your RMSA. Neither you nor your beneficiary(ies) can sell, transfer, assign or pledge your interest in the RMSA. Your RMSA cannot be attached or garnished for any reason or taken, voluntarily or involuntarily, for the satisfaction of debts or other obligations, including claims for alimony, support, separate maintenance and claims in bankruptcy proceedings. Therefore no “Qualified Domestic Relations Orders,” or “QDROs,” will be recognized for the RMSA.

Using Your RMSA
You control when and how you use your RMSA. After you retire, you can use your account balance to help pay for all or a portion of your health care premiums after retirement by submitting receipts for premiums and proof of eligible coverage types and coverage dates to UnitedHealthcare, the RMSA administrator. You can use your balance for the Cost of Prudential-sponsored Retiree health care coverage or for premiums for medical, dental, vision and Prescription Drug Coverage that are not sponsored by Prudential (with the exception of other employer coverage, including COBRA, active and retiree programs and coverage you may be eligible for through a Spouse, Domestic Partner’s employer).

You determine which premium payments you would like to submit for reimbursement from your RMSA, as well as what portion of the premiums should be reimbursed. For example, you can elect to submit 100% of your Medicare Part B premiums for the year but only 50% of your dental coverage premiums.

You determine when you would like to have your premium payments reimbursed from the RMSA. There is no time limit for submitting eligible premiums for reimbursement.

Remember, if you have other coverage available, you can defer using your RMSA indefinitely. This way, your RMSA can continue to grow with interest until you are ready to begin to use it.
Please note: If you incur premiums for coverage that would otherwise be eligible for reimbursement but the period of coverage includes any time period prior to your retirement date, those premiums are not eligible for reimbursement from your RMSA. In addition, premiums that include a period of coverage both before and after your retirement date will not be reimbursed on a prorated basis. For example, if your retirement date is January 15 and you are enrolled for Medicare Part B coverage for the month of January, you cannot submit your January monthly premium, in whole or in part, for reimbursement from your RMSA. Since you were not retired for a portion of this month, the entire month’s premium is not eligible. You can submit the cost for your Medicare Part B coverage for reimbursement from your RMSA beginning with your February premium.

RMSA Auto-Reimbursement Option

You can elect to set up automatic reimbursement from your RMSA for all or a percentage of your Prudential medical, dental and/or vision coverage premiums (if applicable based on your enrolled coverages). If you elect the RMSA auto-reimbursement option, you will no longer need to submit a claim form with proof of payment and proof of coverage for your cost for these programs. If you have Dependent(s) covered in a Prudential retiree benefit program, they must also be covered under the RMSA, in order to elect the auto-reimbursement option. If you want to participate in the RMSA auto-reimbursement option, you must make an active election at the time of your retirement or during an Annual Enrollment Period. Please note that you can stop auto-reimbursement at any time, but you can only elect auto-reimbursement during an Annual Enrollment Period.

It may take up to four weeks from the date the premium was paid for you to be reimbursed through the RMSA auto-reimbursement option. For example, if the premium was paid on February 1, you should receive the reimbursement by the end of February.

Highlights of the RMSA

<table>
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<tbody>
<tr>
<td><strong>Health Care Options</strong></td>
</tr>
<tr>
<td>• You may be reimbursed from your RMSA for coverage under Prudential-sponsored programs or non-Prudential-sponsored programs (except other employer-sponsored programs). Your RMSA can be used to reimburse yourself for certain health care premiums (including medical, dental, vision and Prescription Drug premiums); and</td>
</tr>
<tr>
<td>• You may use your RMSA to be reimbursed for the cost of Prudential medical, dental and vision COBRA coverage immediately following retirement.</td>
</tr>
<tr>
<td><strong>Whom You Can Be Reimbursed For</strong></td>
</tr>
<tr>
<td>• The premiums for any individual who is eligible to be covered under a Prudential-sponsored Retiree Medical Program option can be reimbursed by the RMSA. Generally, this includes a Spouse or Qualified Adult and your Dependent Children;</td>
</tr>
<tr>
<td>• You must confirm that the dependents for whom you would like to receive reimbursement are listed on UnitedHealthcare’s website (at <a href="http://www.uhealthaccounts.com">www.uhealthaccounts.com</a>). At any time, you can add or remove dependents through the Prudential Benefits Center website (at <a href="http://www.prubenefitscenter.com">www.prubenefitscenter.com</a>); and</td>
</tr>
<tr>
<td>• Please note that Imputed Income applies if you have a Domestic Partner whom you have identified as being eligible for premium reimbursements from your RMSA, whether or not you use the RMSA to be reimbursed for premiums for your Domestic Partner.</td>
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4 If your coverage level for a Prudential retiree program does not match your RMSA coverage level (for example, “You + Family” for a Prudential retiree program, “You + Spouse” for RMSA), your auto-reimbursement enrollment will be denied, and you will need to submit a claim form with proof of payment and proof of coverage to be reimbursed from the RMSA.
## Highlights of the RMSA

### How You Can Be Reimbursed
- You pay the full premiums for coverage (Prudential or non-Prudential coverage);
- If you choose to enroll for Prudential-sponsored coverage, you are required to have the premiums for that coverage deducted from your pension check, if it is sufficient to pay for the premiums. Otherwise, you will be billed directly;
- You must submit appropriate documentation of your coverage, including your receipts and proof of payment, proof of eligible coverage types and coverage dates to UnitedHealthcare, the RMSA administrator, for both Prudential-sponsored and non-Prudential-sponsored coverage to receive a reimbursement for your health care premiums (until the account is exhausted); and
- You can elect the auto-reimbursement option for Prudential-sponsored coverage during the Annual Enrollment Period or at the time of your retirement, however you may stop auto reimbursement at any time.

### If You Are Enrolled in the Prudential Consumer Directed Health Program 80 or Consumer Directed Health Program 90
- If you are enrolled in a Prudential Consumer Directed Health Program (CDHP) option and continue in a CDHP option as a Retiree, the amount in your Health Fund will continue to be available for claims under a CDHP option;
- If you are enrolled in a CDHP option and your annual Health Fund exceeds the limit of $800 for individual coverage or $1,600 if you are covering yourself and others, the excess amount will be transferred to your RMSA on or after April 30 of the new program year; and
- If you do not remain enrolled in a CDHP option at retirement or disenroll for any reason in the future (including becoming eligible for Medicare), any Health Fund balance automatically will be transferred to your RMSA after 120 days. You will not lose your accumulated Health Fund if you cease enrollment in the Prudential CDHP option after you Retire.

### COBRA
- Generally, if you are not eligible for Medicare and you have the RMSA, enrolling in COBRA continuation coverage is less expensive than the Prudential Retiree Medical Program. This is because 102% of the cost of active Employee coverage continued under COBRA is less than 100% of the cost of Retiree coverage. Upon retirement, Prudential will offer you the opportunity for COBRA continuation coverage under the Medical Program option in which you were enrolled as an active Employee. If you elect COBRA continuation coverage, you should waive Prudential Retiree medical coverage until your COBRA period is exhausted (generally a maximum of 18 months). At that time, you will be able to choose a Prudential-sponsored Retiree Medical Program option. Choosing COBRA immediately after retirement does not count toward the one-time Retiree medical coverage enrollment rule.

## Your RMSA Resources

Please refer to the Financial Support for Your Retiree Health Care: Planning for Your Future brochure, the RMSA Resources Guide for more information.

Visit the UnitedHealthcare website at [www.uhchealthaccounts.com](http://www.uhchealthaccounts.com) to access information about your RMSA. Once you are registered and log on, you can:

- See your current balance; and
- See the account details for your RMSA, including all transactions, such as interest applied to your account, Health Fund transfers, reimbursements issued to you and corresponding dates for these activities.

## Cost of Coverage

The amount of your contribution under the Retiree Medical Program depends on whether you have the Credit Approach or the Retiree Medical Savings Account (RMSA), which Retiree Medical Program option you select, whether you and/or your covered Spouse or Qualified Adult is eligible for Medicare, how many Qualified Dependents you cover and where you live, in some cases. In addition, you may pay annual Deductibles, Copays or Coinsurance toward the expenses of care and services, depending on the program you choose.
If you enroll for coverage for yourself and your Domestic Partner and you have the Credit Approach, or you have the RMSA and list your Domestic Partner or as someone for whom you could seek reimbursement from the RMSA for eligible expenses, Imputed Income may apply and you may be subject to additional income and employment tax on the Imputed Income amount. (See “Imputed Income for Domestic Partner Coverage” beginning on page 25 for more information.)

Because Domestic Partners generally do not satisfy the definition of a dependent under the Internal Revenue Code, Prudential is required to add to your income an amount representing the fair market value of providing coverage for your Domestic Partner, less any After-Tax contributions, if applicable (that is, the Imputed Income amount). Generally, the fair market value equals the difference between the Consolidated Omnibus Budget Reconciliation Act (COBRA) rate for You Only coverage and You + Spouse/Qualified Adult coverage, less the 2% administrative fee usually included in these rates. You will be subject to applicable federal income and employment (for example, Social Security and Medicare) tax withholding on the Imputed Income amount.

Please note: If you cover a Domestic Partner, you may also be subject to state income tax withholding on the Imputed Income amount, depending on your resident state’s tax laws.

To determine the current contribution amounts, visit the Prudential Benefits Center website (at www.prubenefitscenter.com), or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Each year during the Annual Enrollment Period, you will be notified of what you have to pay for each option.

IRS Circular 230 disclosure: Neither Prudential nor its representatives are authorized to provide tax or legal advice or financial advice on behalf of the Program. Any tax information provided is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code. You are encouraged to consult with your tax, financial and/or legal advisors for advice regarding your particular situation.

For Retirements Prior to January 1, 2008
Employees who were eligible for the Retiree Medical Program and Retired prior to January 1, 2008, have the Credit Approach available to help them pay for the Cost of their Retiree health care coverage. Please see “The Credit Approach” beginning on page 6 for more information.

For Retirements On or After January 1, 2008, and Prior to January 1, 2011
Eligible Employees who Retire prior to January 1, 2011, had a one-time irrevocable choice at retirement to elect the method Prudential will use to help finance their health care coverage after they Retire—either the Credit Approach or the RMSA. Please see “The Credit Approach” beginning on page 6 and “The Retiree Medical Savings Account (RMSA)” beginning on page 8 for more information.

For Retirements On or After January 1, 2011
Employees who are eligible for the Retiree Medical Program and Retire on or after January 1, 2011, have the RMSA available to help them pay for the Cost of their Retiree health care coverage. The Credit Approach is not available to Retirees who Retire on or after January 1, 2011. Please see “The Retiree Medical Savings Account (RMSA)” beginning on page 8 for more information.

For Long Term Disability Participants

Long Term Disability Participants Who Began Receiving Long Term Disability Benefits Prior to January 1, 2008
If you had ten or more years of Vesting Service as of the date you commenced benefits under the Long Term Disability Program, while you are receiving LTD benefit payments, Prudential will contribute toward the Cost of your Retiree Medical Program coverage through the Credit Approach. The amount of the credit is fixed (that is, it will not increase in future years) and is based on your years of continuous service when your Long Term Disability benefits began, your Medicare status, the Medicare status of your covered Spouse or Qualified Adult, if applicable, and, whether you are
covering Dependent Children. The only time the credit that applies to you or your Spouse or Domestic Partner will change is when you or your Spouse or Domestic Partner become eligible for Medicare.

**Long Term Disability Participants Who Began Receiving Long Term Disability Benefits On or After January 1, 2008**

If you had ten or more years of Vesting Service as of the date you commenced benefits under the Long Term Disability Program, while you are receiving LTD benefit payments, Prudential will contribute toward the Cost of your Retiree Medical Program coverage through the Credit Approach. The amount of the credit is fixed (that is, it will not increase in future years) and is based on your years of continuous service when your Long Term Disability benefits begin, your Medicare status, the Medicare status of your covered Spouse or Qualified Adult, if applicable, and, whether you are covering Dependent Children. The only time the credit that applies to you or your Spouse or Domestic Partner will change is when you or your Spouse or Domestic Partner become eligible for Medicare.

And, while you are receiving LTD benefit payments, Prudential will make monthly allocations into an RMSA when you are age 40 and over based on your job grade immediately prior to your commencement of LTD benefits. Your RMSA will continue to grow throughout the period during which you receive LTD benefit payments.

Assuming you remain totally disabled under the terms of the Long Term Disability Program (see the *Disability Program* SPD booklet for more information), when you stop receiving LTD benefit payments at the time you attain your LTD maximum benefit duration, your financial support for Retiree Medical Program coverage under the Credit Approach will end, and you may begin to use your RMSA to reimburse yourself for the Cost of certain medical, pharmacy, vision and dental premiums for you and your eligible covered Dependents.

If your LTD benefits end for any reason and you have not reached the maximum benefit duration, unless you were eligible for Retiree Medical Program benefits as a Retiree when LTD benefits began, your Retiree Medical Program coverage will cease and the RMSA will be forfeited unless you return to active full-time work and are eligible for active Employee Medical Program coverage.

**For Surviving Dependents**

**Surviving Dependents of a Retiree**

If you are eligible for Retiree Medical Program coverage as a Surviving Dependent of a Retiree (see “Surviving Dependent Eligibility” beginning on page 18), and the deceased Retiree had the Credit Approach, Prudential will contribute toward the Cost of your Retiree Medical Program coverage through the Credit Approach. If the deceased Retiree had the RMSA, the RMSA balance, if any, will be available to you. The amount in the RMSA will be equal to the Retiree’s current account balance at the time of death. If the Retiree’s balance is zero, however, no account will be available.

**Surviving Dependents of a Long Term Disability Participant Who Began Receiving Long Term Disability Benefits Prior to January 1, 2008**

If you are eligible for Retiree Medical Program coverage as a Surviving Dependent of a Long Term Disability participant who began receiving Long Term Disability benefits prior to January 1, 2008 (see “Surviving Dependent Eligibility” beginning on page 18), Prudential will contribute toward the Cost of your Retiree Medical Program coverage through the Credit Approach.

**Surviving Dependents of a Long Term Disability Participant Who Began Receiving Long Term Disability Benefits On or After January 1, 2008**

If you are eligible for Retiree Medical Program coverage as a Surviving Dependent of a Long Term Disability participant who began receiving Long Term Disability Benefits on or after January 1, 2008 (see “Surviving Dependent Eligibility” beginning on page 18), Prudential’s financial support under the Credit Approach will end and the deceased Long Term Disability participant’s RMSA balance, if any, will be available to you. The amount in the RMSA will be equal to the Long Term Disability participant’s current account balance at the time of death. If the Long Term Disability participant’s balance is zero, however, no account will be available. There is no one-time spousal allocation in this
situation. Please note that even if you are not eligible for Retiree Medical Program coverage, you may still be eligible for the deceased Long Term Disability participant’s RMSA balance.

Surviving Dependents of an Active Employee with Ten or More Years of Vesting Service Who Died Prior to January 1, 2008

If you are eligible for Retiree Medical Program coverage as a Surviving Dependent of an active Employee with ten or more years of Vesting Service (see “Surviving Dependent Eligibility” beginning on page 18), Prudential will contribute toward the Cost of your Retiree Medical Program coverage through the Credit Approach.

Surviving Dependents of an Active Employee with Ten or More Years of Vesting Service Who Died On or After January 1, 2008

If you are eligible for Retiree Medical Program coverage as a Surviving Dependent of an active Employee with ten or more years of Vesting Service (see “Surviving Dependent Eligibility” beginning on page 18), the Credit Approach is not available to you. The deceased Employee’s RMSA balance, if any, will be available to you. The amount in the RMSA will be equal to the Employee’s current account balance at the time of death. If the Employee’s balance is zero, however, no account will be available. There is no one-time spousal allocation in this situation. Note that the RMSA can be used to pay for Prudential-sponsored coverage continued through COBRA. Please note that even if you are not eligible for Retiree Medical Program coverage, you may still be eligible for the deceased Employee’s RMSA balance.
Joining the Prudential Retiree Medical Program

In this section, you will find the Retiree Medical Program’s rules for Retiree, Long Term Disability participant and Surviving Dependent eligibility, as well as information about enrolling in a Retiree Medical Program and changing from one program to another. Also included is some general information about the Cost of your coverage and your out-of-pocket expenses.

Retiree Eligibility

Who Is Eligible

In order to be eligible for benefits under a Retiree Medical Program option, you must meet certain requirements, as described below.

*If you were employed by or affiliated with Prudential as:*

- A Full-Time Employee;

- A Part-Time Employee who was scheduled to work at least 20 hours per week other than a part-time field force marketing assistant⁵; or

- An Agency Distribution Financial Professional.

*You are eligible to participate in the Retiree Medical Program if, when your employment with Prudential ends, you:*

- Have a Benefits Eligibility Date on or after January 1, 2001 (see the “Benefits Eligibility Date” section on page 19 for more information on Benefits Eligibility Dates);

- Have ten or more years of Vesting Service (as defined under the Retirement Plan and including any periods of Vesting Service granted under The Prudential Welfare Benefits Plan for the purpose of eligibility); and

- Either:
  - Have attained the first day of the month coinciding with or next following your 55th birthday; or
  - Are considered a Retired participant under the terms of The Prudential Traditional Retirement Plan Document (a component of the Retirement Plan).

If hired after January 1, 2001, you are eligible only if you have at least ten years of Vesting Service and have attained the first day of the month coinciding with or next following your 55th birthday at the time your employment with Prudential ends.

In addition, you may be eligible if you were an Employee affected by the outsourcing of Employees to IBM. Contact the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits for more information.

Who Is Not Eligible

You are not eligible to participate in the Retiree Medical Program described in this SPD booklet if you were:

- Included in a collective bargaining unit, unless the collective bargaining agreement specifically provided for participation in the program;

- An Employee of a non-participating affiliate;

⁵ If you were a part-time field force marketing assistant and were enrolled in the Prudential Medical Program on August 1, 2000, and continuously covered until retirement, you are eligible for coverage under the Retiree Medical Program.
• An International Employee;
• A temporary or occasional Employee;
• An individual service provider compensated through an employee leasing company, temporary employment agency or other third party agency;
• An individual who would have been treated as an employee solely by reason of such individual being treated as either part of an “affiliated service group” or a “leased employee” under the Internal Revenue Code and regulations;
• An independent contractor (other than an Agency Distribution Financial Professional);
• A person retained on a monthly fee or per diem basis;
• An examining physician or other person rendering services solely on the basis of fees;
• A person working under the direction of real estate management firms or other contractors;
• A part-time field force marketing assistant;
• A student intern hired or re-hired on or after June 1, 2007;
• An Agency Distribution Probationary Financial Professional hired on or after September 1, 2008, and who participates in a development program within Agency Distribution pursuant to an employment agreement for a period of time that is not expected to exceed 26 weeks; or
• Any other person who performed services for Prudential but was not treated by Prudential as an Employee for Federal tax purposes.

Please refer to the Plan Documents for a complete listing of the classes of Employees who are ineligible to participate in the Retiree Medical Program. If you would like to request a copy of the Plan Document, you should write to the Plan Administrator at the address shown in the “Plan Administrator” section beginning on page 190.

Qualified Dependent Eligibility

If you meet the eligibility requirements beginning on page 15, you may cover Qualified Dependents under the Retiree Medical Program. Following are the rules and guidelines for covering Qualified Dependents and other Qualified Adults (such as a Domestic Partner or an Extended Family Member).

Please note: Your Qualified Dependents are eligible for coverage if you elect coverage for yourself and they meet the criteria summarized beginning below and described in detail in the Glossary definitions of “Spouse,” “Qualified Adult,” “Domestic Partner,” “Extended Family Member,” “Dependent Child(ren),” “Qualifying Child” or “Qualifying Relative.” Age limitations apply for Extended Family Member and Dependent Child(ren) coverage. Please see the Glossary beginning on page 217 for more information.

Your Qualified Dependents are:

• Your Spouse or one Qualified Adult. A Qualified Adult is defined as your same-sex or opposite-sex Domestic Partner or an Extended Family Member; and

• Your Dependent Child(ren) (as defined in the Glossary beginning on page 220) who generally are:

6 If you were a part-time field force marketing assistant and were enrolled in the Prudential Medical Program on August 1, 2000, and continuously covered until retirement, you are eligible for coverage under the Retiree Medical Program.

7 Some HMOs may not cover Qualified Adults. See the Annual Enrollment materials provided during the Annual Enrollment Period or contact the carrier for details.
— Up to age 19, for unmarried grandchildren and children living in your home for whom you are the legal guardian, if additional requirements are met (see the callout box below for more information about eligibility for your grandchildren);

— Up to age 26, for your natural children, your adopted children, children placed with you for adoption and your stepchildren (regardless of their student, marital or tax-dependent status);

— Age 26 or older and who are unmarried, incapable of sustaining employment due to a mental or physical disability and are Substantially Dependent on you, as long as the child qualified at the time of enrollment and continues to qualify as either your “Qualifying Child” or “Qualifying Relative,” as described in the Glossary beginning on page 233; or

— Any child required to be covered under either a Qualified Medical Child Support Order or a National Medical Support Notice.

Please note: Different age limits apply for Dependent Children who are your unmarried grandchildren.

You may enroll your unmarried grandchild as a Dependent Child as follows:

• Up to age 19, when:
  • Your child—the parent or stepparent (who has legal custody) of the grandchild—meets the definition of a Dependent Child, and is covered under the Program as a Dependent Child (your child cannot be covered as an Extended Family Member if the grandchild is to be covered as a Dependent Child);
  • Your grandchild qualifies as a “Qualifying Child” or “Qualifying Relative” (as defined in the Glossary) under the Internal Revenue Code (the “Code”). See the “Special Exception Related to Multiple Support Agreements for a Child Who Has Attained at Least Age 26 and for a Grandchild” section beginning below; and
  • Your grandchild is living in your household or is a full-time student at an Educational Institution.

• Between the ages of 19 and 26, if your grandchild:
  • For the period between the ages of 19 and 24, is a full-time student at an Educational Institution;
  • Is Substantially Dependent on you;
  • Qualifies as a “Qualifying Child” or “Qualifying Relative” (as defined in the Glossary) under the Internal Revenue Code (the “Code”). See the “Special Exception Related to Multiple Support Agreements for a Child Who Has Attained at Least Age 26 and for a Grandchild” section beginning below; and
  • Participated in the Prudential Medical Program or Retiree Medical Program at the time he/she attained age 19.

Coverage is continued without regard to whether:

• Your unmarried child—the parent or stepparent (who has legal custody) of the grandchild—continues to have legal custody of your grandchild; or

• Your grandchild continues to live in your home.

Please see “Dependent Child(ren)” in the Glossary beginning on page 220 for more information.

Special Exception Related to Multiple Support Agreements for a Child Who Has Attained at Least Age 26 and for a Grandchild

There is a multiple support agreement exception to the above rules for determining whether your child who has attained age 26 or your grandchild is your “Qualifying Child” or “Qualifying Relative” for purposes of eligibility under the Retiree Medical Program. Under this exception, your child who has attained age 26 or your grandchild will qualify as a “Qualifying Relative” if such child or grandchild satisfies each of the following:

• No one person contributes over one-half of your child or grandchild’s support;
• Over one-half of your child or grandchild’s support for the Calendar Year must be received from two or more persons, each of whom could have claimed your child or grandchild as a dependent but for the fact that such person alone did not contribute over one-half of such support; and

• Each person who contributes over 10% of your child or grandchild’s support (other than you) files with the Internal Revenue Service Form 8332 (“Release/Revocation of a Release of Claim to Exemption”) under Section 152(e) of the Code that he/she will not claim the child or grandchild as a dependent on his/her Federal income tax return for the Calendar Year for which you are requesting coverage. You must also file the Certification Form described below with the Prudential Benefits Center and upon request you must submit a copy of Form 8332 to the Prudential Benefits Center.

If this exception applies and the Form 8332 is signed by each person contributing over 10% to your child or grandchild’s support (other than you), your child or grandchild will be treated as your “Qualifying Relative” for purposes of determining your child’s eligibility under the Retiree Medical Program.

Certification Form
If you intend to rely upon the multiple support exception to cover a child who has attained age 26 or a grandchild under the Retiree Medical Program for any Calendar Year, you also need to submit a separate Certification Form regarding your child or grandchild’s eligibility for this exception to the Prudential Benefits Center prior to obtaining coverage for the child or grandchild.

For more information, and/or to obtain a copy of the separate Certification Form, please call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Important Notice Regarding Civil Union Partnership
Certain states have passed legislation that requires insurers (such as some Health Maintenance Organizations) to provide equal benefit coverage for civil union partners, if spousal coverage is provided through an employer’s group insurance plan.

If you live in a state that has passed such legislation and want to enroll a civil union partner in the Retiree Medical Program, you may enroll yourself and your civil union partner in an insured program only. However, if your civil union partner qualifies as a Domestic Partner, you may enroll your civil union partner as a Domestic Partner in any Retiree Medical Program option that offers coverage for Domestic Partners.

For more details regarding eligibility requirements for these programs, please contact the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Long Term Disability Participant Eligibility
If you had ten or more years of Vesting Service as of the date you commenced benefits under the Long Term Disability Program, you are eligible for benefits under the Retiree Medical Program described in this SPD booklet.

Surviving Dependent Eligibility
Surviving Dependents of an eligible Prudential Retiree, an eligible Long Term Disability participant or an eligible active Employee with ten or more years of Vesting Service are eligible for benefits under the Retiree Medical Program. You qualify as a Surviving Dependent, if, at the time of the eligible Retiree’s, Long Term Disability participant’s or active Employee’s death, you were covered under a Prudential-sponsored medical program as a Spouse or Dependent Child. If you were not covered under a Prudential-sponsored medical program as a Spouse or Dependent Child at the time of the death, you are not eligible for coverage under the Retiree Medical Program. Domestic Partners, Extended Family Members and civil union partners are not eligible for coverage as Surviving Dependents. For Surviving Dependent Spouses, coverage will terminate upon remarriage. For Dependent Children, the eligibility guidelines for Dependent Children under “Qualified Dependent Eligibility” beginning on page 16 apply.
If you are the Spouse or Dependent Child of a Retiree, Long Term Disability participant or an active Employee with ten or more years of Vesting Service but you do not qualify as a Surviving Dependent, then you are not eligible for coverage under the Retiree Medical Program. However, you may be eligible for financial support for Retiree health care premiums through the deceased Retiree’s, Long Term Disability participant’s or active Employee’s RMSA if:

- You did not qualify as a Surviving Dependent because you were not covered under a Prudential-sponsored medical program;

- The deceased person was an eligible Prudential Retiree who had the RMSA;

- The deceased person was an eligible LTD participant with a Benefits Eligibility Date of January 1, 2008, or later, who was eligible for Retiree medical benefits as of the date he/she commenced benefits under the Long Term Disability Program; or

- The deceased person was an active Employee who had ten or more years of Vesting Service and was considered eligible for Retiree Medical Program coverage.

The amount in the RMSA will be equal to the deceased person’s current account balance at the time of death. If the deceased person’s balance is zero, however, no account will be available. There is no one-time spousal allocation in this situation. Note that the RMSA can be used to pay for Prudential-sponsored coverage continued through COBRA. Surviving Dependents will receive information about the RMSA directly from UnitedHealthcare, the RMSA administrator. See “The Retiree Medical Savings Account (RMSA)” beginning on page 8 for more information.

**Benefits Eligibility Date**

The Retiree Medical Program options available to benefits-eligible individuals are based on your Medicare eligibility and your Benefits Eligibility Date (and in some cases, where you live). To determine your Benefits Eligibility Date, please note:

- **Retirees**: Your Benefits Eligibility Date is your retirement date (the first day following your last day of employment). If you became a Retiree because you reached the maximum duration of benefits under the Long Term Disability Program, your Benefits Eligibility Date will continue to be the date you commenced benefits under the Long Term Disability Program;

- **Long Term Disability Participants**: Your Benefits Eligibility Date is the date you commenced benefits under the Long Term Disability Program; or

- **Surviving Dependents**: If the Employee upon whose service your benefits are based died before retirement, your Benefits Eligibility Date is the date of that Employee’s death. If that Employee died after retirement or commencement of Long Term Disability, your Benefits Eligibility Date is that Employee’s retirement date or date of commencement of Long Term Disability.

**Enrollment**

It is important to understand the enrollment choices available to you and your Qualified Dependents—and to make the appropriate choice when you are first eligible for coverage under the Retiree Medical Program. Please read the following carefully.

You will have a choice between COBRA continuation coverage (continues access to the active Medical Program option in which you were enrolled, and you pay 102% of the full Cost for the coverage, generally for a maximum of 18 months) and Retiree Medical Program coverage (at Retiree contribution rates). Or, you may choose neither and waive coverage.

Generally, if you are not yet eligible for Medicare, it may be less expensive to select COBRA coverage immediately upon your retirement before you commence enrollment in Retiree Medical Program coverage. This is because 102% of the Cost of active Employee coverage is less than 100% of the Cost of Retiree coverage.
Prudential is required to offer you COBRA because retirement is considered a COBRA Qualifying Event. This means that shortly before your active coverage ends (when possible), you will receive a COBRA Election Package, offering you the opportunity to enroll for COBRA continuation coverage. The COBRA Election Package is sent prior to the date your active coverage ends (when possible) to allow time for you to review the COBRA offering and related information. If you choose to elect COBRA continuation coverage, once your COBRA benefits are exhausted you will have the opportunity to enroll in the Prudential Retiree Medical Program. If you wish to enroll for Retiree Medical Program coverage immediately upon your retirement, you must decline COBRA continuation for medical coverage.

If you wish to elect COBRA continuation of your active medical coverage rather than Retiree Medical Program coverage, you must make your COBRA election on the Prudential Benefits Center website or by calling the Prudential Benefits Center by the deadline indicated on the COBRA Election Form. You will also need to pay for your coverage in a timely manner. Remember, if you waive Prudential Retiree Medical Program coverage and instead enroll for COBRA immediately following retirement, you will still have one opportunity to enroll for Prudential Retiree Medical Program coverage in the future. For example, you may decide to enroll in Prudential Retiree Medical Program coverage within 60 days of the exhaustion or other loss of Prudential COBRA continuation coverage, at any future Annual Enrollment Period or at any time in the future, within 31 days on and following the date of the loss of other medical coverage.

If you do not receive your COBRA Election Package within a few weeks of your retirement, please call the Prudential Benefits Center, the COBRA administrator, at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits and then COBRA.

Please note: You cannot be covered under both COBRA and Retiree Medical Program coverage. Upon retirement, you must choose one (or choose neither). If you wish to decline Retiree Medical Program coverage and enroll for COBRA continuation coverage, you must waive Retiree Medical Program coverage upon retirement. If you wish to enroll for Retiree Medical Program coverage, you must waive COBRA continuation coverage and enroll for Retiree Medical Program coverage. Failure to make your COBRA election in a timely manner constitutes waiving COBRA continuation coverage. If you take no action, you will be deemed to have waived COBRA and Retiree Medical Program coverage and to have declined coverage altogether.

If you choose not to enroll in Prudential-sponsored Retiree medical coverage immediately upon retirement, you will have one opportunity to elect such coverage at a later date. However:

- If you initially defer coverage, later choose to enroll in Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time; or

- If you initially enroll for Prudential-sponsored Retiree medical coverage and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time.

Enrolling for Retiree Medical Program Coverage Upon Retirement

If you wish to be covered under the Retiree Medical Program upon retirement, you must enroll in a program option under the Retiree Medical Program. Some options are very similar to the options available to active Employees. However, there are differences.

If you fail to enroll in the Retiree Medical Program when you Retire, you will default to no coverage under the Retiree Medical Program.

If you are not enrolled in an active Prudential Medical Program option when you Retire:

- You may enroll in a Retiree Medical Program option upon retirement;

- You may enroll in a Retiree Medical Program option during a subsequent Annual Enrollment Period and your coverage will take effect the following January 1; or
• You may enroll in a Retiree Medical Program option if you experience a Qualified Change in Status.

In most cases, if you wish to enroll in a Retiree Medical Program option, you must make your elections on the Prudential Benefits Center website (at www.prubenefitscenter.com). When you process your enrollment through the Prudential Benefits Center website, you will look there to find the instructions and guidance you will need for completing the process and confirming your enrollment. On the Prudential Benefits Center website, you will be able to elect or waive participation in the Retiree Medical Program. You may enroll yourself and any Qualified Dependents in the Retiree Medical Program. Your opportunity to make these elections will begin up to 90 days prior to your retirement date and will continue for 31 days on and following your actual retirement date.

If you do not have access to a computer or the Internet or you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

To enroll your Domestic Partner or a new Extended Family Member, you must follow the certification process on the Prudential Benefits Center website (at www.prubenefitscenter.com). (If you wish to enroll a civil union partner, you must follow the Domestic Partner certification process and select the civil union partner indicator.) If you wish to change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

If you would like to enroll your Dependent Child who is age 26 or older and who is unmarried, incapable of sustaining employment due to a mental or physical disability and is Substantially Dependent on you (as described under “Dependent Child(ren)” in the Glossary beginning on page 220), you may do so by calling the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits. You will be required to furnish medical evidence of the Dependent Child's disability upon request from your medical program carrier.

Call the Prudential Benefits Center if you wish to make changes to your elections due to a Qualified Change in Status, you wish to enroll for coverage if you initially declined coverage at retirement (if eligible) or you have any questions as to whether you are properly completing your transaction.

If you elect to enroll in a Retiree Medical Program option, your coverage under the new program will take effect on the date of your retirement, provided you enroll within the 31-day period on and following your retirement date. If you do not meet the 31-day deadline for enrolling yourself or a Qualified Dependent, you will need to wait until the next Annual Enrollment Period unless you have a Qualified Change in Status. (See “Qualified Change in Status” beginning on page 27 for more information.) If you elect to enroll in a Medicare Advantage Program or Medicare Cost Program, see the following box for details on when your coverage will take effect.

**Please note:** Your coverage under a Medicare Advantage Program or Medicare Cost Program will take effect on the first day of the month following the month in which you enroll and submit the required enrollment form to the Prudential Benefits Center, but not earlier than the date you become eligible for Medicare. See “Medicare Advantage Programs” beginning on page 161 and “Medicare Cost Program” beginning on page 165 for more information. You will be covered under Retiree Medical Program E – Indemnity from the date of your retirement until the date on which your Medicare Advantage Program or Medicare Cost Program coverage takes effect. If you do not sign and return the Medicare Advantage Program or Medicare Cost Program enrollment form in a timely manner, you will not have coverage under that specific Medicare Advantage Program or Medicare Cost Program. You will instead be covered under Retiree Medical Program E – Indemnity until the next Annual Enrollment Period.

If, at a later time, you acquire any additional Qualified Dependents (see “Qualified Change in Status” beginning on page 27), you may enroll them by calling the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.
Please note: If you Retire on or after January 1, 2008, and you choose not to enroll in Prudential-sponsored Retiree medical coverage immediately upon retirement, you will have one opportunity to elect such coverage at a later date. However:

- If you initially defer coverage, later choose to enroll in Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time; or
- If you initially enroll for Prudential-sponsored Retiree medical coverage and your coverage is discontinued for any reason (including failure to make timely premium payments), you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time.

**Enrollment and Election Changes**

In most cases, if you wish to enroll for Retiree Medical Program coverage, you may submit your election via the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)). When you process your enrollment through the Prudential Benefits Center website, you will look there to find the instructions and guidance you will need for completing the process and confirming your enrollment. If you do not have access to a computer or the Internet or if you need more information, you may contact the Prudential Benefits Center by calling 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.

Call the Prudential Benefits Center if you wish to make changes to your elections due to a Qualified Change in Status, you wish to enroll for coverage if you initially declined coverage at retirement (if eligible) or you have any questions as to whether you are properly completing your transaction.

**Enrolling in Coverage After You Previously Declined Coverage**

**If You Retired Prior to January 1, 2008**

You may enroll in a Retiree Medical Program option:

- During a subsequent Annual Enrollment Period and your coverage will take effect the following January 1; or
- If you lose other coverage mid-year or experience a Qualified Change in Status mid-year you may not have to wait until the next Annual Enrollment Period to enroll (see “Qualified Change in Status” beginning on page 27 for more information).

**If You Retired On or After January 1, 2008**

If you choose not to enroll in Prudential-sponsored Retiree medical coverage immediately upon retirement, you will have one opportunity to elect such coverage at a later date. However:

- If you initially defer coverage, later choose to enroll in Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason, you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time; or
- If you initially enroll for Prudential-sponsored Retiree medical coverage, and your coverage is discontinued for any reason, you will not be permitted to re-enroll for Prudential-sponsored Retiree medical coverage at any future time.

You may enroll in a Retiree Medical Program option:

- During a subsequent Annual Enrollment Period and your coverage will take effect the following January 1; or
- If you experience a Qualified Change in Status (see “Qualified Change in Status” beginning on page 27 for more information).
Enrollment and Election Changes

If you wish to enroll after you initially declined coverage at retirement, call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Enrolling in Coverage Upon Qualification as a Long Term Disability Participant

You will have a choice between COBRA continuation coverage (continues access to the active Medical Program in which you were enrolled, and you pay 102% of the full Cost for the coverage, generally for a maximum of 18 months) and Retiree Medical Program coverage (at Retiree contribution rates under the Credit Approach).

While you are receiving Long Term Disability benefit payments, enrolling in the Retiree Medical Program is currently less expensive than COBRA continuation coverage, in most cases. However, since the end of employment (which generally occurs at the exhaustion of STD benefits) is a COBRA Qualifying Event, Prudential is required to offer the opportunity for COBRA continuation coverage under the Medical Program option in which you were enrolled as an active Employee. In connection with this opportunity, a few weeks after you exhaust your STD benefits, you will receive a COBRA Qualifying Event package.

If you decide to enroll in the Retiree Medical Program, you must decline COBRA continuation coverage. You may not enroll for coverage under both COBRA and the Retiree Medical Program.

Upon exhaustion of STD benefits, and the commencement of your eligibility as a Long Term Disability participant, you may elect only one form of coverage, or you may decline coverage altogether.

You may not enroll at a later date if:

- You do not enroll in a Retiree Medical Program option when you are first eligible; or
- You enroll for Retiree Medical Program coverage and your coverage is discontinued for any reason.

Enrollment and Election Changes

The Prudential Benefits Center website at www.prubenefitscenter.com is your primary resource when you need to enroll for coverage. When you process your enrollment through the Prudential Benefits Center website, you will look there to find the instructions and guidance you will need for completing the process and confirming your enrollment. If you do not have access to a computer or the Internet, if you wish to make changes to your elections due to a Qualified Change in Status, change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member or if you have any questions as to whether you are properly completing your transaction, call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Enrolling in Coverage Upon Qualification as a Surviving Dependent

For Surviving Dependents of a Retiree

The Prudential Benefits Center will notify you regarding how to continue your Retiree Medical Program coverage. Generally, the Retiree Medical Program coverage you were enrolled in prior to the Retiree’s death will automatically continue, as long as you continue to be eligible. However, you may need to change to a different Retiree Medical Program option if you are no longer eligible for the specific option you had before the Retiree’s death. Eligibility will depend on your eligibility for Medicare and the Retiree’s Benefits Eligibility Date. The Prudential Benefits Center will notify you and/or your Dependent Child(ren) of your eligibility to continue coverage and your options for coverage. You will not be required to elect COBRA continuation coverage at this time, nor will you be required to pay the COBRA rates discussed under “How to Purchase Continued Medical Coverage” on page 209.

For Surviving Dependents of a Long Term Disability Participant

The Prudential Benefits Center will notify you regarding how to continue your Retiree Medical Program coverage. Generally, the Retiree Medical Program coverage you were enrolled in prior to the Long Term Disability participant’s death will automatically continue, as long as you continue to be
eligible. However, you may need to change to a different Retiree Medical Program option if you are no longer eligible for the specific option you had before the Long Term Disability participant’s death. Eligibility will depend on your eligibility for Medicare and the Long Term Disability participant’s Benefits Eligibility Date. The Prudential Benefits Center will notify you and/or your Dependent Child(ren) of your eligibility to continue coverage and your options for coverage. You will not be required to elect COBRA continuation coverage at this time, nor will you be required to pay the COBRA rates discussed under “How to Purchase Continued Medical Coverage” on page 209.

Even if you were not enrolled in Prudential-sponsored coverage, you may still be eligible for the deceased Long Term Disability participant’s RMSA balance, if any, and can use it to reimburse yourself for any eligible non-Prudential-sponsored health care coverage premiums (see “For Surviving Dependents” beginning on page 13 for more information). Eligible Surviving Dependents will receive information about the RMSA directly from UnitedHealthcare, the RMSA administrator.

For Surviving Dependents of an Active Employee with Ten or More Years of Vesting Service

You will have 90 days from the date of the eligible active Employee’s death to elect Prudential-sponsored Retiree medical coverage (60 days for COBRA coverage). If coverage is not elected in that timeframe, you will no longer be eligible for Prudential-sponsored coverage.

You may not enroll at a later date if:

- You do not enroll in a Retiree Medical Program option when you are first eligible;
- You do not enroll in a Retiree Medical Program option immediately following exhaustion of COBRA continuation coverage (if applicable); or
- You enroll for Retiree Medical Program coverage and your coverage is discontinued for any reason.

Even if you do not enroll in Prudential-sponsored coverage, you may still be eligible for the deceased Employee’s RMSA balance, if any, and can use it to reimburse yourself for any eligible non-Prudential-sponsored health care coverage premiums (see “For Surviving Dependents” beginning on page 13 for more information). Eligible Surviving Dependents will receive information about the RMSA directly from UnitedHealthcare, the RMSA administrator.

Enrollment and Election Changes

The Prudential Benefits Center website at www.prubenefitscenter.com is your primary resource when you need to enroll for coverage. When you process your enrollment through the Prudential Benefits Center, you will look there to find the instructions and guidance you will need for completing the process and confirming your enrollment. If you do not have access to a computer or the Internet, if you wish to make changes to your elections due to a Qualified Change in Status or if you have any questions as to whether you are properly completing your transaction, call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Which Programs Are Available to You

The following Retiree Medical Programs are available to you, your Qualified Dependents and/or your Surviving Dependents if you meet the eligibility requirements, depending on your eligibility for Medicare, and, in some cases where you live.

If you are not Medicare-eligible:

- Retiree Medical Program E – High Deductible Health Program (HDHP);
- Retiree Medical Program E – Consumer Directed Health Program 80 (CDHP 80);
- Retiree Medical Program E – Consumer Directed Health Program 90 (CDHP 90);
- Health Maintenance Organizations (HMOs); and
• Retiree Medical Program E – Indemnity (for residents of Hawaii only).

If you are Medicare-eligible:
• Retiree Medical Program E – Indemnity;

• Medicare Advantage Programs; and

• Medicare Cost Program.

Please note: The above Retiree Medical Program, Medicare Advantage Program and Medicare Cost Program options may not be available in all locations. Please visit the Prudential Benefits Center website (at www.prubenefitscenter.com), or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits to determine which options are available to you.

You and your Covered Qualified Dependents must choose the same Retiree Medical Program option unless:
• You or your Qualified Dependents have chosen COBRA coverage (see “Continuing Your Coverage” beginning on page 207 for more information on COBRA); or

• Your Qualified Dependents are covered as Surviving Dependents after your death.

Imputed Income for Domestic Partner Coverage

If You Have the Credit Approach

If you enroll for coverage for yourself and your Domestic Partner and you have the Credit Approach, the portion of the Cost of coverage provided by Prudential for your Domestic Partner is taxable. Since Domestic Partners generally do not satisfy the definition of a dependent under the Internal Revenue Code, Prudential is required to include in your compensation an amount representing the fair market value of providing coverage for your Domestic Partner, less any After-Tax contributions, if applicable (that is, the Imputed Income amount).

Generally, the fair market value equals the difference between the Consolidated Omnibus Budget Reconciliation Act (COBRA) rate for You Only coverage and You + Spouse/Qualified Adult coverage, less the 2% administrative fee usually included in this rate. You will be subject to applicable federal income and employment (for example, Social Security and Medicare) tax withholding on the Imputed Income amount.

Please note: If you enroll for coverage for yourself and your Domestic Partner, you may also be subject to state income tax withholding on the Imputed Income amount, depending on your resident state’s tax laws.

IRS Circular 230 disclosure: Neither Prudential nor its representatives are authorized to provide tax or legal advice or financial advice on behalf of the Program. Any tax information provided is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code. You are encouraged to consult with your tax, financial and/or legal advisors for advice regarding your particular situation.

If You Have the RMSA

If you have the RMSA, Imputed Income will only apply if you list your Domestic Partner as someone for whom you may seek reimbursement from the RMSA for eligible expenses. Otherwise, Imputed Income will not apply. The Imputed Income amount, if any, will be subject to applicable federal income and employment tax withholding.

Please note: If you cover a Domestic Partner, you may also be subject to state income tax withholding on the Imputed Income amount, depending on your resident state’s tax laws.
IRS Circular 230 disclosure: Neither Prudential nor its representatives are authorized to provide tax or legal advice or financial advice on behalf of the Program. Any tax information provided is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code. You are encouraged to consult with your tax, financial and/or legal advisors for advice regarding your particular situation.
Making Changes to Your Retiree Medical Coverage

Annual Enrollment Period
You may elect to change your medical coverage during the Annual Enrollment Period. Generally, you may disenroll at any time. However, you may not make other mid-year enrollment changes (such as changing programs or enrolling yourself and/or a Qualified Dependent) unless you experience a Qualified Change in Status (see “Qualified Change in Status” beginning below for more information) or a loss of coverage (see “Loss of Other Coverage (For Retirees Only)” on page 29 for more information).

The elections you make during the Annual Enrollment Period will be effective on January 1 of the following Calendar Year.

If you wish to change programs during the Annual Enrollment Period, here are the options that may be available to you based on your Medicare eligibility and where you live:

• You may move to a different Retiree Medical Program option;

• You may move from a Retiree Medical Program to an HMO, Medicare Advantage Program or Medicare Cost Program; or

• You may move from your current HMO, Medicare Advantage Program or Medicare Cost Program to another HMO, Medicare Advantage Program, Medicare Cost Program or Retiree Medical Program option, if available. (See “Which Programs Are Available to You” beginning on page 24 for more information.)

Please note: Special procedures apply if you elect coverage or change your coverage under a Medicare Advantage Program or Medicare Cost Program during the Annual Enrollment Period. You and your Medicare-eligible Dependents may be required to complete enrollment and/or disenrollment forms. (See “Medicare Advantage Programs” beginning on page 161 and “Medicare Cost Program” beginning on page 165 for more information.)

Qualified Change in Status
Normally, if you want to enroll for coverage or change programs, you must wait until the Annual Enrollment Period. However, if you experience a Qualified Change in Status, you may make a change in coverage without waiting for the Annual Enrollment Period, as long as the change in coverage that you request is consistent with the Qualified Change in Status and provided you notify the Prudential Benefits Center within the 31-day period on and following the date of the Qualified Change in Status. Otherwise, you will not be allowed to make a change other than disenrollment (disenrollments are generally permitted at any time).

If you are a Retiree and are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in the Retiree Medical Program if you or your Dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your Dependents’ other coverage).

As long as you submit your notification through the Prudential Benefits Center website at www.prubenefitscenter.com or by calling the Prudential Benefits Center within the 31-day period on and following the date of the Qualified Change in Status, your enrollment change will take effect as of the date of the Qualified Change in Status. You should call the Prudential Benefits Center if:

• You wish to change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member;
• You wish to enroll an eligible unmarried Dependent Child age 26 or older who is incapable of sustaining self-supporting employment due to a mental or physical disability;

• You wish to make an enrollment change that is consistent with your Qualified Change in Status;

• You do not have access to a computer or the Internet; or

• You need more information.

Please note: Special procedures apply if you elect coverage or change your coverage under a Medicare Advantage Program or Medicare Cost Program due to a Qualified Change in Status. You and your Medicare-eligible Dependents may be required to complete enrollment and/or disenrollment forms. (See “Medicare Advantage Programs” beginning on page 161 and “Medicare Cost Program” beginning on page 165 for more information.)

If you miss the 31-day deadline, you will not be able to make a change until the next Annual Enrollment Period. If you attempt to enroll after this 31-day period, the change will not be allowed.

For birth, adoption or placement for adoption, if you previously elected You + Child(ren) or You + Family coverage, you may add the child to the existing coverage after the 31-day period. The coverage will be retroactive to the date of birth, adoption or placement for adoption, or, in the case of HMO, Medicare Advantage Program or Medicare Cost Program coverage, as far back as the carrier will permit from the date notice is received by the Prudential Benefits Center. (See “Medicare Advantage Programs” or “Medicare Cost Program,” beginning on page 161 and page 165, for more information.)

You will be responsible for paying your portion of the Cost of your changed coverage beginning with the month following the month in which your changed coverage takes effect.

Please note that this list does not include all changes in status. Qualified Changes in Status include (but are not limited to):

• Your marriage, divorce, legal separation or annulment;

• The birth, adoption or placement of a child for adoption;

• A Qualified Adult becoming eligible for coverage;

• Losing coverage from your HMO, Medicare Advantage Program or Medicare Cost Program due to your moving out of the network service area, if enrolled in an HMO, Medicare Advantage Program or Medicare Cost Program;

• Losing coverage from any Prudential Retiree Medical Program option due to your moving to Hawaii, if you are not eligible for Medicare;

• Losing coverage due to your moving out of Hawaii, if enrolled in Retiree Medical Program E – Indemnity or the Kaiser – Hawaii HMO and if you are not eligible for Medicare;

• Loss of Retiree Medical Program E – HDHP, CDHP 80, CDHP 90 or HMO coverage due to becoming Medicare-eligible;

• A change of coverage under a Qualified Dependent’s employer plan;

• Exhaustion of other COBRA coverage by you, your Spouse or Qualified Dependents; or

• A change in the employment status of you, your Spouse or Qualified Dependents (including a change in work site or change in place of residence) which affects the benefits enrollment for you or your Qualified Dependents.

Qualified Changes in Status do not include events such as (but not limited to):

• Your Retiree Medical Program option Participating Provider dropping out of the network;
• Any errors you make during the enrollment process; or

• Your misunderstanding of the Program or provisions of the Retiree Medical Program option in which you are enrolled.

**Any change you request due to a Qualified Change in Status must be consistent with the change in your status.**

**Loss of Other Coverage (For Retirees Only)**

If you are a Retiree and you or your Qualified Dependents do not enroll in the Retiree Medical Program when you are first eligible to enroll, you may enroll later (without waiting for the Annual Enrollment Period) if you have a loss of other coverage and you have not exhausted your one-time opportunity to enroll. This means that at the time you first declined to enroll in the Retiree Medical Program:

• You had COBRA continuation coverage through another program and that coverage has now come to an end; or

• You had other health insurance (through another employer, for example) and you lose this coverage because you are no longer eligible for it, or employer contributions for the coverage have stopped.

You or your Qualified Dependents must enroll in the Retiree Medical Program within the 31-day period on and following the date of your Qualified Change in Status. If you enroll within the 31-day period, your enrollment will take effect on the date of the Qualified Change in Status.

**Please note:** Special procedures apply if you elect coverage or change your coverage under a Medicare Advantage Program or Medicare Cost Program due to a Qualified Change in Status. You and your Medicare-eligible Dependents may be required to complete enrollment and/or disenrollment forms. (See “Medicare Advantage Programs” beginning on page 161 and “Medicare Cost Program” beginning on page 165 for more information.)

**How Loss of Other Coverage Works**

Here is an example of how a Retiree may enroll in the Retiree Medical Program following a loss of other coverage. Joe retires from Prudential and takes another job that offers medical benefits. He declines Prudential Retiree medical benefits. Later, he leaves the other job and loses his medical benefits. Because Joe has not used his one-time opportunity to enroll in the Retiree Medical Program, Joe can enroll in the Retiree Medical Program, but he must ask to enroll within the 31-day period on and following the date his benefits at the other job end. (See the instructions below for requesting enrollment.) Otherwise, Joe must wait until the next Annual Enrollment Period to enroll for coverage, which will be effective on the following January 1.

**Enrollment Following a Loss of Other Coverage**

Visit the Prudential Benefits Center website at [www.prubenefitscenter.com](http://www.prubenefitscenter.com) to enroll. If you wish to change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member, if you do not see your Qualified Change in Status online, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.
How Identification Cards Work Under the Retiree Medical Program

This section describes the identification cards you will receive for the Retiree Medical Program and explains how they work.

Remember, if you have a question about your benefits, visit the Prudential Benefits Center website (at www.prubenefitscenter.com). If you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits. If you have a question about specific Retiree Medical Program provisions, call your carrier’s member services.

Your Retiree Medical Program Identification Card

When you enroll in one of the Retiree Medical Program options, you will receive an identification card. Your identification card contains important information. It also provides the carrier’s member services telephone number to call for Precertification, if necessary.

Be sure to carry your identification card with you at all times and show it whenever you receive medical care. If you lose your identification card, call your carrier’s member services and they will send you a new one. If you need to receive care while you are waiting for a new identification card, your provider can call your carrier’s member services to verify your eligibility for coverage.

Your Identification Card for Prescription Drug Benefits

You will receive a separate identification card for Prescription Drug benefits from Express Scripts (your identification card may refer to Medco), unless you are enrolled in a local HMO, Medicare Advantage Program or Medicare Cost Program (or you are enrolled in a Medicare Advantage Program and you have a non-Medicare-eligible Dependent covered by the Aetna or UnitedHealthcare (UHC) Companion Coverage). You must show your Express Scripts identification card to the pharmacist at your participating pharmacy whenever you purchase Prescription Drugs. If you lose your card, call Express Scripts member services at 1-800-557-0803 and Express Scripts will send you a new one. Please note that non-Medicare-eligible Dependents enrolled in companion coverage under the Aetna or UHC Medicare Advantage Programs will also receive a separate Retiree Prescription Drug Program identification card from Express Scripts.

If you are enrolled in Retiree Medical Program E – HDHP, Cigna will partner with Express Scripts to administer your Prescription Drug benefit. You will receive a separate identification card from Express Scripts.
The Retiree Prescription Drug Program

If you participate in the CDHP 80, the CDHP 90, the Aetna HMO or the Retiree Medical Program E – Indemnity described in this SPD booklet, your Prescription Drug coverage will be provided under the Retiree Prescription Drug Program administered by Express Scripts. You must purchase Prescription Drugs through the retail network or the Express Scripts PharmacySM home delivery service feature of the Retiree Prescription Drug Program, or you will be responsible for the full cost, except in the event of an Emergency.

For participants in the CDHP 80, the CDHP 90, the Aetna HMO or the Retiree Medical Program E – Indemnity, Prescription Drug expenses do not apply toward the Retiree Medical Program option’s annual Deductible or Annual Out-of-Pocket Maximum. In addition, for participants in the CDHP 80 and the CDHP 90, Prescription Drug expenses will not draw down your Health Fund.

Please note: If you elect coverage under the HDHP, a local HMO, a Medicare Advantage Program or a Medicare Cost Program, your Prescription Drug benefits will be provided according to the provisions of those medical programs and will not be covered under the Retiree Prescription Drug Program administered by Express Scripts.

If you elect coverage through the Aetna or UHC Medicare Advantage Program and cover a non-Medicare-eligible Qualified Dependent under companion coverage, the Prescription Drug benefits for your non-Medicare-eligible Qualified Dependent will be provided by the Retiree Prescription Drug Program, not the companion coverage. See the “Companion Coverage” section beginning on page 168 for more information.

The Retiree Prescription Drug Program Administered by Express Scripts

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar minimums and maximums as the table below illustrates.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retiree Prescription Drug Program Administered by Express Scripts¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum² and a $20.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
</tbody>
</table>

¹ The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

² At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.
Other Important Features | Prescription Drug Benefits
---|---
Fertility Drugs (Oral and Injectables) | $6,000 Maximum Lifetime Benefit (this limit is combined for retail and the Express Scripts Pharmacy home delivery prescriptions)

The Pharmacy Network

Retail pharmacy benefits under the Retiree Prescription Drug Program are available only through participating retail pharmacies that are part of the Express Scripts network. You have access to a network of participating retail pharmacies that offer a high level of service to ensure that you and your Qualified Dependents receive cost-effective, quality pharmaceutical care. When you need to fill a prescription, you can select from a broad range of participating retail pharmacies, including national chains, as well as local pharmacies in your community.

Lists of participating retail pharmacies are available separately from this SPD booklet, at no cost to you. If you need a listing of participating retail pharmacies, several resources are available:

- Visit the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) to locate a participating retail pharmacy or contact Express Scripts member services at 1-800-557-0803; or
- Visit the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)), where a link to the Express Scripts website is available.

Filling a Prescription

When you or a Covered Qualified Dependent needs to fill a prescription, the Retiree Prescription Drug Program administered by Express Scripts offers you a choice:

- **Visit a participating retail pharmacy:** Through the Retiree Prescription Drug Program administered by Express Scripts, you can visit a participating retail pharmacy, show your Express Scripts identification card (your identification card may refer to Medco) and pay the appropriate Coinsurance (or the appropriate minimum or maximum amount) for each covered Generic Drug, Brand-Name Preferred Drug or Brand-Name Non-Preferred Drug (up to a 30-day supply). See the table on page 31 for more information. You will likely pay more for a Brand-Name Drug so you may want to ask your doctor to prescribe a Generic Drug (either a Generic Alternative or Generic Equivalent Drug) whenever possible. Generic Alternatives contain different active ingredients than Brand-Name Drugs, but may provide a similar effect when treating a specific condition. FDA-approved Generic Equivalent Drugs contain the same active ingredients as their Brand-Name Drug counterparts and are the same in strength, purity, quality and dosage form. Generic Equivalent Drugs are taken the same way as the Brand-Name Drug counterparts. If a Generic Equivalent Drug is not available, ask your doctor if a Generic Alternative is appropriate for you to take. Generic Alternatives and Generic Equivalent Drugs generally cost less than Brand-Name Drugs.

There is no annual Deductible to pay and there are no claim forms to file.

The Retiree Prescription Drug Program provides you with an identification card to use at participating retail pharmacies. Your Express Scripts identification card (your identification card may refer to Medco) is also available on your mobile device when you log in to the Express Scripts mobile application (“app”). You can download the app for free when you search for “Express Scripts” from your mobile device app store. Your Express Scripts identification card will indicate to the pharmacist that you have Prescription Drug coverage. You must show your identification card to the pharmacist at your participating retail pharmacy whenever you purchase Prescription Drugs. If you fill a prescription at a participating retail pharmacy without presenting your Express Scripts identification card, your Prescription Drugs will not be covered and you will be responsible for 100% of the drug cost.

If you choose to purchase Prescription Drugs from a pharmacy that does not participate in the Express Scripts network, your Prescription Drugs will not be covered. You will be responsible for
100% of the cost of drugs purchased at non-participating pharmacies, except in the case of Emergencies.

- **Use the home delivery Prescription Drug program:** Through the Express Scripts Pharmacy, you can order up to a 90-day supply of covered medications for the appropriate Coinsurance (or the appropriate minimum or maximum amount) for a Generic Drug, a Brand-Name Preferred Drug or a Brand-Name Non-Preferred Drug. See the table on page 31 for more information.

There is no annual Deductible to pay.

Through the Express Scripts Pharmacy, you can purchase up to a 90-day supply of long-term maintenance medications, typically at a lower cost than what you would pay for three 30-day supplies of the same medication at a participating retail pharmacy. Maintenance medications are drugs taken to help control a chronic health condition, such as high blood pressure, diabetic conditions, arthritis and ulcers. For more information about covered conditions, contact Express Scripts member services.

To order your medication through the home delivery program:

- Fill out a Health Assessment Questionnaire and the Express Scripts Pharmacy Order Form (included with your Program materials and available at www.Express-Scripts.com);

- Send your completed forms, along with the original prescription from your doctor and payment for your medication. To determine the cost of the prescription and to calculate the amount of Coinsurance required, visit the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts member services at 1-800-557-0803. If you are a first-time visitor to the website, please take a moment to register. Please have your member number available.

- See “*My Rx Choices*” beginning on page 35 for more information about finding available lower-cost options for medications you take on an ongoing basis;

- You can pay by check, e-check, money order or credit card. In most cases, you will receive your medication within 14 days after your order is received; or

- For refills, log in to the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) or the Express Scripts mobile app, or you can use the form included with your last prescription order through the Express Scripts Pharmacy. You can also order your refill by phone by calling 1-800-4REFILL (1-800-473-3455). It is a toll-free number and you can call 24 hours a day, 7 days a week.

For more information about the Express Scripts Pharmacy, call Express Scripts member services at 1-800-557-0803.

**Covered Prescription Drugs**

Prescription Drug coverage under the Retiree Prescription Drug Program (both the retail and home delivery programs) includes most medications prescribed by a licensed health care provider. If you are uncertain whether or not a drug is covered, contact Express Scripts member services at 1-800-557-0803 or log in to the Express Scripts website (at [www.Express-Scripts.com](http://www.Express-Scripts.com)), select “Price a medication” from the drop-down menu under “Manage Prescriptions” and follow the prompts.

Covered Prescription Drugs under the Retiree Prescription Drug Program include, but are not limited to:

- AIDS-related drugs;
- Anabolic steroids (not for athletic use);
- Compounds containing at least one Federal Legend Drug;
- Contraceptive devices;
- Diaphragms;
• Emergency allergy kits;
• Federal Legend Drugs;
• Glucose test strips;
• Growth hormones;
• Imitrex (sumatriptan);
• Immunosuppressants;
• Infertility drugs (subject to a Maximum Lifetime Benefit—please see the “Other Important Features” table on page 32 for more information);
• Insulin (needles and syringes);
• Isotretinoin;
• Lancets;
• Oral contraceptives;
• Prenatal prescription vitamins;
• Prescription and over-the-counter smoking cessation products;
• Prescription vitamins;
• Retin-A/Avita/Altinac cream (non-cosmetic uses); and
• Self-administered injectable drugs.

Preventive Medications
The Retiree Prescription Drug Program covers the following preventive medications—both prescription and over-the-counter (OTC)—at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy.

• Aspirin—an OTC product for ages 45 to 79 for cardiovascular protection;

• Contraceptives—most FDA-approved products, including:
  — Generic oral contraceptives (hormonal). Brand-name products with a generic equivalent are not covered at 100% unless your health care provider determines that the generic is medically inappropriate;
  — OTC contraceptives, including emergency contraceptives, with a prescription through age 50;
  — Single-source brand-name oral contraceptives that do not have a generic equivalent available;
  — Single-source brand-name transdermal patches and vaginal ring;
  — Brand-name barrier contraceptives such as the diaphragm that do not have a generic equivalent available;
  — Brand-name implanted devices and contraceptives such as Mirena IUD that do not have a generic equivalent available; and
— Single-source brand-name injectable contraceptive medications (for example, Depo-Provera) that do not have a generic equivalent available;

- Folic acid—OTC doses of 400 to 800 mcg/day for women through the age of 50 who are pregnant or who are planning to become pregnant;

- Fluoride—a prescription product for children through the age of five to prevent dental cavities;

- Iron supplements—an OTC product for children less than one year of age;

- Smoking cessation products—some OTC and some prescription products for members age 18 and older (limited to up to 180 days of therapy per year), including:
  - Nicotrol NS;
  - Nicotrol Inhaler;
  - Zyban;
  - Chantix;
  - Nicorette Gum/Lozenge; and
  - Nicotine Transdermal System;

- Vitamin D supplements for members age 65 and older (effective January 1, 2014); and

- Bowel preparation for colonoscopy screening (effective January 1, 2014).

**Express Scripts’ National Preferred Formulary**

Visit the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) to find out if a Prescription Drug is included on the Express Scripts National Preferred Formulary and to find cost information for specific Prescription Drugs based upon the Retiree Prescription Drug Program design.

A formulary is a list of Prescription Drugs that pharmacy benefit managers, like Express Scripts, develop based on each drug’s effectiveness in terms of treatment and cost. The Express Scripts National Preferred Formulary includes a broad list of prescription medications. However, not all drugs are included on this preferred list. If your prescription medication is not on the preferred list, you may wish to discuss alternatives with your physician.

To determine if a Prescription Drug is included on the formulary, log in to the Express Scripts website ([www.Express-Scripts.com](http://www.Express-Scripts.com)), select “Price a medication” from the drop-down menu under “Manage Prescriptions” and follow the prompts. You may also call Express Scripts member services at 1-800-557-0803 to speak with a member services representative to obtain this information.

Please note that the Express Scripts National Preferred Formulary may include certain Prescription Drugs that are excluded from coverage under Prudential’s Retiree Prescription Drug Program administered by Express Scripts. The inclusion of a medication on the Express Scripts National Preferred Formulary is not a guarantee of coverage under the Retiree Prescription Drug Program—the program’s exclusions of specific medications still apply.

**My Rx Choices**

The **My Rx Choices** prescription savings program is offered by Express Scripts, your Prescription Drug benefit manager. **My Rx Choices** is an online prescription savings tool designed to help you find potential lower-cost options for Prescription Drugs available under your program.

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8 *Note that My Rx Choices presents options for long-term maintenance medications (medications that you take on an ongoing basis) only.*
To use *My Rx Choices*, follow these steps:

1) Log in to *My Rx Choices* (at [www.Express-Scripts.com/choices](http://www.Express-Scripts.com/choices)). If you have not yet registered as a member on the Express Scripts website, you will need to register before you can access *My Rx Choices*. Please have your Express Scripts identification card (your identification card may refer to Medco) handy. If you prefer to access *My Rx Choices* by telephone, call 1-800-319-7750. **Please note:** The telephone number for *My Rx Choices* is different from the Express Scripts member services telephone number you use for other questions; and

2) Check to see if there are any lower-cost options available for the medications you take on an ongoing basis.

*My Rx Choices* shows you any available lower-cost options, including Generic Drugs, and how much you could save by switching to a lower-cost medication. Please note that *My Rx Choices* does not show possible OTC alternatives. You will need to speak with your physician regarding any OTC alternatives that may be appropriate for you.

You also have the opportunity to print a report of your available lower-cost options so that you can review them with your physician. There are forms included to make it easy for your physician to submit a new prescription to the Express Scripts Pharmacy, your home delivery pharmacy.

Your doctor knows which medications are right for you but he/she may not know how much they cost. *My Rx Choices*, offered by Express Scripts, provides you with lower-cost options available under your program so that you and your doctor can make the most informed decisions based on health and cost. **No prescription is ever changed without your doctor’s approval.**

You can also access *My Rx Choices* from your mobile device when you download the Express Scripts mobile app for free, enabling you to see whether there are lower-cost options under your program while in the doctor’s office.

If you are looking for a medication on *My Rx Choices* that you take regularly and can’t find it, or if you are taking a Prescription Drug that is not a long-term maintenance medication and you would like to determine if there are potential alternatives, call Express Scripts member services at 1-800-557-0803.

For pertinent details and disclosures regarding *My Rx Choices*, visit the website (at [www.Express-Scripts.com/choices](http://www.Express-Scripts.com/choices)).

**Pre-Authorization for Prescription Drugs**

Prudential is committed to keeping the cost of your Prescription Drugs down while providing you with the coverage you need. With this goal in mind, Express Scripts uses a set of coverage review programs to determine how the Retiree Prescription Drug Program will cover certain Prescription Drugs.

These programs fall under two categories: coverage review and review for the amount of coverage. Programs under both categories may review some or all of the following information:

- The diagnosis or condition for which the Prescription Drug is being prescribed;
- Dosing and/or duration of therapy;
- Patient drug history for prior and simultaneous medication use; and
- Age and gender of the patient.

**Coverage Review**

For some Prescription Drugs, you must obtain pre-authorization through the coverage review process in order to obtain coverage. A coverage review is performed to determine whether your use of the drug qualifies for coverage under the Retiree Prescription Drug Program’s current criteria. You, your doctor or your pharmacist may request a coverage review by calling Express Scripts member services at 1-800-753-2851. **Please note:** The telephone number for coverage review is different from the Express Scripts member services telephone number you use for other questions.
The following drugs or drug categories will require a coverage review with Express Scripts and your doctor. This list is subject to change:

- AIDS-related drugs (Selzentry);
- Allergy and Asthma agents (Xolair);
- Androgen and Anabolic steroids;
- Anti-Interleukins (Arcayst, Ilaris);
- Antinarcoleptic agents (Nuvigil, Provigil);
- Antineoplastic and Immunomodulator agents;
- Antiviral agents (Incivek, Victrelis);
- Appetite suppressants and weight loss therapy;
- Cholesterol lowering agents (Lovaza, Vescepa);
- Chronic obstructive pulmonary disease (COPD) agents (Daliresp);
- Cushing's syndrome related hyperglycemia agents (Korlym);
- Diabetic ulcer agents (Regranex);
- Erythroid stimulants;
- Gastrointestinal agents (Chenodal);
- Growth hormones;
- Hereditary angioedema agents (Firazyr);
- Infertility agents;
- Interferons;
- Miscellaneous dermatological agents (brand tetracyclines, Elidel, Protopic, Retin-A, Tazorac);
- Miscellaneous hormones (Acthar);
- Multiple Sclerosis therapy;
- Myeloid stimulants;
- Neurological agents (Xenazine);
- Osteoarthritis agents (Solaraze);
- Osteoporosis agents (Forteo);
- Pain management (fentanyl, Lidoderm);
- Phenylketonuria agents (Kuvan);
- Prostate cancer GnRh analogs;
- Psoriasis therapy (Stelara);
• Pulmonary agents (Kalydeco);
• Pulmonary Arterial Hypertension agents; and
• Rheumatological agents.

If your claim is denied after consideration of the information in Express Scripts’ records, you have the right to appeal the decision. Information on how to request an appeal will be included in the decision letter that you receive. See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information on benefit claims and how to appeal a denied benefit claim.

**Review for the Amount of Coverage**

The Retiree Prescription Drug Program provides coverage for a quantity of medication and duration of treatment sufficient to meet the needs of most patients. A review for the amount of coverage is required to determine if a greater quantity of medication or longer course of treatment meets established coverage criteria.

The following drugs or drug categories may require a review for the amount of coverage. This list is subject to change:

• Allergy agents (oral antihistamines and nasal sprays);
• Anti-fungal agents;
• Anti-Influenza agents;
• Antineoplastic and Immunomodulator agents;
• Antiviral agents;
• Asthma agents (short- and long-acting inhalers);
• Chronic obstructive pulmonary disease (COPD) agents;
• Contraceptives—emergency and injectable forms;
• Emergency allergy kits;
• Eye condition medication/agents (Restasis);
• Hypnotics;
• Intranasal steroids;
• Migraine therapy;
• Nausea and vomiting agents;
• Non-sedating antihistamines; and
• Ulcer therapy.

**Requesting a Coverage Review or a Review for the Amount of Coverage**

If you submit a prescription to a participating retail pharmacy for a medication that requires a coverage review or a review for the amount of coverage, you, your doctor or your pharmacist may initiate the review by calling Express Scripts member services at 1-800-753-2851. Please note that the telephone number for coverage review is different from the Express Scripts member services telephone number you use for other questions.
Your doctor will be sent a **Coverage Management Review Fax Form** to fill out and send back to Express Scripts at the fax number indicated on the form. When you use the Express Scripts Pharmacy home delivery service, Express Scripts will call your doctor to start the coverage review process. Express Scripts will send you and your doctor a letter confirming whether or not coverage is approved (usually within two business days of receiving the necessary information).

If coverage is approved, you will pay your normal Coinsurance (subject to appropriate minimum and maximum dollar amounts) for the Prescription Drug.

If coverage is not approved, you will be responsible for the full cost of the Prescription Drug at a participating retail pharmacy. While the review process is pending, if you choose to fill the prescription rather than wait for the completion of the review process, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request an appeal will be included in the decision letter that you receive. See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information on benefit claims and how to appeal a denied benefit claim.

To have your claim for benefits considered, you need to file your claim within one year from the date your claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim.

**Prescription Drug Expenses Not Covered**

The list of drugs not covered under the Retiree Prescription Drug Program includes, but is not limited to:

- Nutritional/dietary supplements;

- OTC drugs and medications (except non-prescription insulin and certain OTC preventive medications prescribed by a physician that are covered at 100%, as described beginning on page 34) and Prescription Drugs that have an OTC equivalent available, such as Zantac;

- Injectable drugs that are not self-administered;

- Non-Federal Legend Drugs;

- Drugs for the treatment of erectile dysfunction, such as Viagra;

- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only; and

- Emergency contraceptives that are available OTC (except OTC emergency contraceptives prescribed by a physician that are covered at 100%, as described beginning on page 34).

**Please note:** The Express Scripts National Preferred Formulary may exclude some medications from select drug categories from coverage under Prudential's Retiree Prescription Drug Program administered by Express Scripts.

If you are not sure whether or not a drug is covered, call Express Scripts member services at 1-800-557-0803.

**Additional Discounts Available Through Express Scripts**

Another benefit of having your program administered by Express Scripts is a feature that offers you a discount on prescription medications that are not covered by the Retiree Prescription Drug Program. To take advantage of these discounts, order your out-of-program prescriptions, such as Propecia, Viagra and Renova, through the Express Scripts Pharmacy home delivery service. You do not have to sign up for anything to get these discounts.

For your convenience, you can order your discounted medications using the same home delivery prescription form and envelope that you would normally use to order home delivery prescriptions. Be sure to include the full payment for your discounted medications when you send in your order so it can be processed.
You can check the prices for these discounted medications by visiting the Express Scripts website at www.Express-Scripts.com or by calling Express Scripts member services at 1-800-557-0803.

**Filing Claims for Prescription Drugs**

Your Coinsurance (subject to appropriate minimum and maximum dollar amounts) is the only payment you are required to make for participating retail pharmacy and home delivery Prescription Drugs. There are no claims to file.

In the event of an Emergency, if you are unable to visit a participating retail pharmacy, you will need to pay in full for a prescription and then file a claim with Express Scripts for reimbursement. You can request a reimbursement claim form by contacting Express Scripts member services at 1-800-557-0803 or by visiting the Express Scripts website (at www.Express-Scripts.com). Instructions on how to fill out the form and where to send it are printed on the back of the claim form.

Remember that prescriptions purchased at non-participating pharmacies are not covered by the Retiree Prescription Drug Program administered by Express Scripts, except in the event of an Emergency. If you have a prescription filled at a pharmacy that does not participate in the Express Scripts network, you will not be reimbursed by the Retiree Medical Program. You will be responsible for the full cost of the prescription, except in the event of an Emergency.

The submission of your prescription to the pharmacy does not constitute a claim for benefits under the claims procedures outlined in this SPD booklet. If, after submitting your prescription to the pharmacy, you feel that you were not provided with the benefits you are entitled to under the Program, and you want to make a claim for benefits, you must file a claim form with Express Scripts member services. The claim form should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

If your claim is denied, you have the right to appeal the decision (see “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information). You may also contact Express Scripts member services at 1-800-557-0803 for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet this deadline, your claim will be denied.

**Coordination of Benefits for Prescription Drugs**

Under the Coordination of Benefits provision, the Retiree Prescription Drug Program will coordinate with another program to pay benefits up to 100% of Covered Charges for Prescription Drugs but no more than the percent it would normally pay for Covered Charges if the Retiree Prescription Drug Program were the only payer.

For example, suppose your Spouse is covered under his/her employer’s program and that program pays for Brand-Name Prescription Drug benefits based on 60% Coinsurance. You cover your Spouse as a Qualified Dependent under Retiree Medical Program E – CDHP 80, which includes the Retiree Prescription Drug Program. Your Spouse fills a prescription at a participating retail pharmacy for a Brand-Name Preferred Drug that costs $300. Assuming your Spouse has met any annual Deductible under his/her employer’s program, his/her employer’s program would pay $180 toward Covered Charges. Your Spouse’s costs for the Brand-Name Preferred Drug would have been $45 under the Retiree Prescription Drug Program (25% x $300 = $75, subject to a $45 maximum), if it were the primary program. The Retiree Prescription Drug Program would have paid $255 ($300 – $45) if it were the primary program. Since your Spouse has already received benefits of $180 under his/her employer’s program, the Retiree Prescription Drug Program would reimburse your Spouse $120 ($300 – $180 = $120) because the remaining cost of the drug, $120, is less than the $255 the Retiree
Prescription Drug Program would have paid if it was the only program. The result of the Coordination of Benefits provision is that your Spouse had 100% of the Covered Charge paid for between the two programs.

Prescriptions filled at pharmacies that do not participate in Express Scripts’ network are not covered by the Retiree Prescription Drug Program, except in the event of an Emergency. If your Spouse used a non-participating pharmacy, your Spouse’s Prescription Drug purchase would not be eligible for Coordination of Benefits.

Please note: Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, Aetna HMO and Retiree Medical Program E – Indemnity follow a non-duplication of benefits provision for all services other than Prescription Drug coverage. See the “Non-Duplication of Benefits Provision” section beginning on page 183 for more information.
Retiree Medical Program E – HDHP

Retiree Medical Program E – High Deductible Health Program (HDHP) provides non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents with a full range of health care services after you meet a comparatively high annual Deductible that applies to both In-Network and Out-of-Network services. Under the HDHP, you may choose health care services from Participating Providers—doctors, Hospitals and health care facilities that have agreed to provide Covered Services at reduced or Negotiated Fees—or you may go Out-of-Network to any health care provider you choose. When you use an Out-of-Network provider, you generally pay a higher cost for services than when you use a Participating Provider. As a participant in the HDHP, you may elect to establish and contribute to a Health Savings Account (HSA). If you elect to establish a Cigna HSA administered by JPMorgan Chase, you can fund qualified health care expenses by making personal payment arrangements.

The HDHP is administered by Cigna HealthCare (Cigna). If you have questions regarding your benefits, please contact:

- Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at www.cigna.com/prudential for questions about the HDHP or HDHP claims (for example, benefits, Eligible Expenses, how to file an Out-of-Network claim) and with any questions related to your Cigna HSA contributions, using your HSA debit card to access your HSA funds, other HSA transactions or your HSA investments; or

- The Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, for general eligibility questions about the HDHP and Cigna HSA.

The HDHP is available to all non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents except to those who reside in Hawaii, where the HDHP is not available. Access to Cigna providers varies by location and may be limited in some areas. You should check Cigna’s Participating Providers to ensure you have adequate access to providers before enrolling in the HDHP by going to the Cigna custom website for Prudential or by calling Cigna member services (contact information is listed above).

You can also visit the Prudential Benefits Center website at www.prubenefitscenter.com to find Participating Providers; or call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, to find out if HDHP Participating Providers are available in your area.

How the Program Works

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<td>Annual Deductible²</td>
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<td>Annual Deductible applies to both In-Network and Out-of-Network care</td>
</tr>
<tr>
<td>If you are covering one or more Qualified Dependents, the family annual Deductible must be satisfied before Coinsurance begins</td>
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</table>

| **Out-of-Network**                           |
| Annual Deductible²                          | $1,500 per individual, $3,000 per family |
| Annual Deductible applies to both In-Network and Out-of-Network care |
| If you are covering one or more Qualified Dependents, the family annual Deductible must be satisfied before Coinsurance begins |

| Annual Out-of-Pocket Maximum² (includes annual Deductible) | $4,000 per individual, $8,000 per family | $8,000 per individual, $16,000 per family |
| If you are covering one or more Qualified Dependents, the family Annual Out-of-Pocket Maximum must be met before 100% coverage begins |

Table and footnotes continue on page 43
Retiree Medical Program E – HDHP At-A-Glance

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<td>Program pays 100%, no annual Deductible</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
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<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
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<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
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<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
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<tr>
<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
<td></td>
</tr>
</tbody>
</table>

¹ The HDHP is not available in Hawaii.

² Please note that amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible or the Annual Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.

³ Preventive Care benefits are subject to applicable age and frequency limits. Please contact Cigna for details.

Prescription Drugs Administered by Express Scripts

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<tr>
<th>Prescription Drugs Administered by Express Scripts</th>
<th>Generic</th>
<th>Brand-Name Preferred</th>
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<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>After the HDHP annual Deductible ² is met, you pay 25% Coinsurance, subject to a $5.00 minimum ³ and a $20.00 maximum</td>
<td>After the HDHP annual Deductible ² is met, you pay 25% Coinsurance, subject to a $25.00 minimum ³ and a $45.00 maximum</td>
<td>After the HDHP annual Deductible ² is met, you pay 40% Coinsurance, subject to a $40.00 minimum ³ and a $100.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>After the HDHP annual Deductible ² is met, you pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
<td>After the HDHP annual Deductible ² is met, you pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
<td>After the HDHP annual Deductible ² is met, you pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

¹ The HDHP (in partnership with Express Scripts) covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 64.

² If you are covering one or more Qualified Dependents, the family annual Deductible must be satisfied before Coinsurance begins.

³ At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

For medical expenses, the HDHP offers you the choice of receiving In-Network or Out-of-Network care. For Prescription Drug expenses, the HDHP provides In-Network coverage only. See “Prescription Drug Benefits Under the HDHP” beginning on page 61 for more information. In general, when you receive care:
• **In-Network**, you visit doctors and health care facilities that participate in Cigna’s network of Participating Providers. You need to meet the annual Deductible before the HDHP starts to pay a percentage, called Coinsurance, of your covered health care expenses. Each time you need care and services, your Participating Provider provides the services at a Negotiated Rate—after you have met the annual Deductible, the program pays 90% and you pay 10%. You do not need to file claim forms for In-Network care or services. Eligible Preventive Care services are not subject to the annual Deductible and are covered at 100%. If your costs for In-Network care reach the HDHP’s Annual Out-of-Pocket Maximum, the HDHP will pay 100% of your Covered Expenses for the rest of the Calendar Year; and

• **Out-of-Network**, you can visit any doctor or health care facility. You are responsible for submitting a claim form for reimbursement. You need to meet an annual Deductible before the HDHP starts to pay a percentage, called Coinsurance, of your covered health care expenses. The program pays 70% of Reasonable and Customary (R&C) Fees and you pay 30% plus any amount above R&C Fees. If your costs for Out-of-Network care reach the HDHP’s Annual Out-of-Pocket Maximum, the HDHP will pay 100% of your Covered Expenses (up to R&C Fees) for the rest of the Calendar Year.

**In-Network Benefits**

In-Network benefits are provided by a group of doctors, Hospitals and other health care providers who participate in Cigna’s network. In-Network benefits typically have lower out-of-pocket costs than Out-of-Network benefits. The HDHP pays 100% for eligible In-Network Preventive Care services, which are not subject to the annual Deductible. Each time you receive In-Network care and services, your Participating Provider provides the services at a Negotiated Rate. After you meet the annual Deductible, the HDHP pays 90% and you pay 10% of the Negotiated Rate for Covered Services. (See “Covered Services” beginning on page 46 for more information.)

You do not have to choose a Primary Care Physician (PCP) under the HDHP. You may visit any doctor within the network for routine or specialized care without a referral. Although the HDHP does not require a PCP designation, you may still wish to choose a PCP. Establishing a relationship with a physician who knows you, your medical history and your current needs may help to ensure you receive the most effective care. (See “Your Health Care Providers” in the section that follows for more information.)

**Your Health Care Providers**

When you enroll in the HDHP, you will receive an identification card. You may seek care from any provider in Cigna’s network and services will be covered at the In-Network benefits level after you meet the annual Deductible. Referrals to Specialists are not required. As long as you seek care from a Participating Provider, benefits will be paid at the In-Network benefits level. For any hospitalization, for certain Mental Health and Substance Use Disorder treatment and for certain surgical procedures, Precertification is required. You are responsible for having the care precertified by Cigna. (See “Precertification Rules” beginning on page 71 for more information.)

**Please note**: You will not be allowed to change your Retiree Medical Program option or disenroll mid-year if a Participating Provider leaves the network.

**Where to Find Provider Information**

Provider directories under each health care carrier are available separately from this SPD booklet. If you need provider information, you may call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential (at www.cigna.com/prudential).

Or, visit the Prudential Benefits Center website at www.prubenefitscenter.com to find Participating Providers. You may also call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, and you will be assisted in obtaining provider information at no cost to you.
**Your Annual Deductible**

When you receive In-Network care or services (other than In-Network Preventive Care), you must meet an individual or family annual Deductible before the HDHP will pay benefits.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the HDHP will pay any Covered Expenses at the In-Network benefits level for the rest of that Calendar Year.

The annual Deductible Cross- Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

**Please note:** Amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.

**Individual Annual Deductible**

The individual annual Deductible is $1,500 per Calendar Year.

The individual annual Deductible applies if you have You Only coverage. Your In-Network out-of-pocket expenses must total the individual annual Deductible before Coinsurance begins.

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the individual annual Deductible does not apply to you or your Qualified Dependents.

**Family Annual Deductible**

If you are covering Qualified Dependents, the family annual Deductible is $3,000 per Calendar Year.

The family annual Deductible applies if you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage.

If you are covering one or more Qualified Dependents, the family annual Deductible will be met when any combination of eligible out-of-pocket expenses incurred by you and your Covered Qualified Dependents reaches $3,000.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $2,000 Eligible Expense, then your child incurs a $400 Eligible Expense, and then your Spouse incurs a $2,400 Eligible Expense. The Eligible Expenses of all family members add up to $4,800. As a result, your $3,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $2,400 expense, the first $600 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

**Coinsurance**

Once you have met your annual Deductible, you and the HDHP share in the cost of medical care and services through Coinsurance. The HDHP pays 90% and you pay 10% of the Negotiated Rate for most In-Network Covered Services.

**Annual Out-of-Pocket Maximum**

The HDHP Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maximums Cross-Apply In-Network and Out-of-Network. For example, if you incur $700 toward your In-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the Out-of-Network Annual Out-of-Pocket Maximum, and vice versa.
Please note: Amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

**Individual Annual Out-of-Pocket Maximum**

The individual Annual Out-of-Pocket Maximum for In-Network services under the HDHP is $4,000 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

If you have You Only coverage, once your In-Network out-of-pocket expenses reach the individual maximum, the HDHP will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you.

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the individual Annual Out-of-Pocket Maximum does not apply to you or your Qualified Dependents.

**Family Annual Out-of-Pocket Maximum**

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the family Annual Out-of-Pocket Maximum for In-Network services under the HDHP is $8,000 per Calendar Year. The family maximum will be met when any combination of eligible In-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit.

Once your In-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the HDHP will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

**Maximum Lifetime Benefit for Infertility Treatment**

There is an In-Network Maximum Lifetime Benefit of $20,000 for infertility treatment and a $10,000 Out-of-Network Maximum Lifetime Benefit for infertility treatment that Cross- Applies with the In-Network maximum.

For example, suppose you elect to receive infertility treatment Out-of-Network and the HDHP pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the HDHP will pay up to an additional:

- $2,000 for Out-of-Network treatment for a total of $10,000, the Out-of-Network Maximum Lifetime Benefit; or

- $12,000 for In-Network treatment which, when Cross- Applied with the $8,000 paid Out-of-Network, meets the $20,000 In-Network Maximum Lifetime Benefit.

So, while In-Network treatment will be covered up to the $20,000 Maximum Lifetime Benefit, up to $10,000 of that maximum may Cross-Apply (and reduce that maximum) with treatment received Out-of-Network.

Prescription Drug expenses for infertility treatment have a separate lifetime maximum that does not count toward the HDHP’s infertility treatment Maximum Lifetime Benefit. Under the HDHP’s Prescription Drug coverage there is a $6,000 lifetime maximum for infertility Prescription Drugs (covered In-Network only). Infertility Prescription Drugs do not count toward the HDHP’s lifetime maximum benefit of $20,000 In-Network/$10,000 Out-of-Network.

**Covered Services**

The HDHP covers a wide variety of services as long as the services are Medically Necessary. The list of Covered Services described beginning on page 47 is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.
In-Network care and services include, but are not limited to:

**Preventive Care**

You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most In-Network Preventive Care services are covered at 100%. The annual Deductible does not apply to In-Network Preventive Care services. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations (including travel immunizations);
- Colonoscopies (including related services):
  - Please note: Prudential covers all In-Network colonoscopies and the ancillary services (for example, anesthesia, consultation) at 100%, regardless of whether the screening is preventive or diagnostic. If the ancillary services are not paid at 100%, usually due to billing timing issues, contact Cigna member services at 1-888-502-4462 and they will reprocess the claim accordingly;
- Adult routine physicals:
  - X-ray and lab services are covered at 100% when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;
- Well-woman care:
  - Anemia screening on a routine basis for pregnant women;
  - Bacteriuria urinary tract or other infection screening for pregnant women;
  - For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
  - Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;
  - Breast cancer mammography screenings every one to two years for women over age 40;
  - Breast cancer chemoprevention counseling for women at higher risk;
  - Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
  - Cervical cancer screening (Pap-tests) for sexually active women;
  - Chlamydia infection screening for younger women and other women at higher risk;
  - Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;
— Domestic and interpersonal violence screening and counseling for all women;
— Folic acid supplements for women who may become pregnant;
— Gestational diabetes screening;
  − For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  − Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;
— Gonorrhea screening for all women at higher risk;
— Hepatitis B screening for pregnant women at their first prenatal visit;
— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
— Human Papillomavirus (HPV) DNA testing;
— Osteoporosis screening for women over age 60 depending on risk factors;
— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
— Sexually transmitted infection (STI) counseling for sexually active women;
— Syphilis screening for all pregnant women or other women at increased risk;
— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and
— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 100% when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.

Office Visits
Office Visits are covered at 90% after you meet the annual Deductible unless otherwise noted beginning below and include:

• Non-preventive x-ray and lab services;
• Office Visits (PCP and Specialists) for purposes other than Preventive Care;
• Maternity care:
  — Some prenatal services are covered at 100%. Please see the “Preventive Care” section beginning on page 47 for more details; and
  — Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at www.cigna.com/prudential to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
• Physical, occupational and speech therapy Office Visits (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  — **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

• Chiropractic care (up to 60 days per Calendar Year; the In-Network and Out-of-Network day maximums Cross-Apply); and

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**
Hospital services are covered at 90% after you meet the annual Deductible and include:

• Surgery (Inpatient and Outpatient);

• Semi-private room and board at the Hospital;

• Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);

• Pre-admission testing;

• Outpatient facility and supplies;

• Physical, occupational and speech therapy (Inpatient only) (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  — **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

• Ambulance services if Medically Necessary; and

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**
Other services are covered at 90% after you meet the annual Deductible and include:

• X-rays or lab tests;

• Delivery care and service at a Hospital or birthing center;

• Skilled nursing facility (up to 100 days per Calendar Year In-Network; the maximum Cross- Applies In-Network and Out-of-Network);

• Home Health Care (In-Network days count toward the Out-of-Network day maximum):
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and
  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:

• Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

• Home health aid services;
— Physical, occupational or speech therapy by a qualified therapist;
— Dietary counseling;
— Medical social services;
— Medical supplies, drugs and medicines prescribed by a physician;
— Lab services (provided by or for a Home Health Care agency); and
— Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:
— Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;
— Services that do not require the technical skills of a medical, Mental Health or dental professional;
— Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;
— Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
— Transportation services;
— Services and supplies not Medically Necessary; and
— Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.

If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);
• Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;
• Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $20,000 In-Network lifetime maximum, which Cross-Applies In-Network and Out-of-Network):
— Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits Under the HDHP” beginning on page 61 for more information;
• Infertility procedures are covered if:
– A female member is unable to conceive or produce conception after:

  • One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;
  
  • Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or
  
  • At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);

– The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, a network infertility specialist and the physician who diagnosed the member as infertile;

– The procedures are done while not confined in a Hospital or any other facility as an Inpatient;

– The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;

– Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;

– The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and

– The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

• Durable medical equipment (for example, crutches, wheelchairs, braces);

• Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the HDHP or for surgical removal of a tumor);

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and

• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:

  — Preventive counseling visits (maximum of eight visits per 12 months);

  — Treatment visits; and

  — Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).
For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

- Macromastia or gynecomastia surgeries;
- Abdominoplasty;
- Panniculectomy;
- Redundant skin surgery;
- Removal of skin tags;
- Craniosacral/cranial therapy;
- Prolotherapy;
- Transportation services;
- Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);
- Removal of an implant that alters the appearance of the body (such as breast or chin implants);
- Orthopedic footwear;
- Footwear to accommodate a diabetic condition;
- Surgical treatment of varicose veins;
- Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;
- Home uterine activity monitoring;
- Residential Treatment Centers; and
- Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).

For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**
There are no claim forms required for In-Network services.

**Out-of-Network Benefits**
The HDHP allows you to visit Out-of-Network providers and still receive benefits. When you visit an Out-of-Network provider, you:

- Meet an individual or family annual Deductible before the Program starts to pay benefits; and

- Generally pay the cost of care and services at the time you receive them. You are responsible for submitting a claim form to receive reimbursement for a percentage of Covered Expenses.

**Your Annual Deductible**
When you receive care Out-of-Network, you must meet an individual or family annual Deductible before the Program will pay benefits.
The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the HDHP will pay any Covered Expenses at the Out-of-Network benefits level for the rest of that Calendar Year, up to Reasonable and Customary (R&C) limits. (See “Reasonable and Customary Fees” below for more information.) Any Out-of-Network charges above the R&C limits cannot be applied to the annual Deductible.

The annual Deductible Cross Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

Please note: Amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.

**Individual Annual Deductible**

The individual annual Deductible is $1,500 per Calendar Year.

The individual annual Deductible applies if you have You Only coverage. Your Out-of-Network out-of-pocket expenses must total the individual annual Deductible before Coinsurance begins.

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the individual annual Deductible does not apply to you or your Qualified Dependents.

**Family Annual Deductible**

If you are covering Qualified Dependents, the family annual Deductible is $3,000 per Calendar Year.

The family annual Deductible applies if you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage.

If you are covering one or more Qualified Dependents, the family annual Deductible will be met when any combination of eligible out-of-pocket expenses incurred by you and your Covered Qualified Dependents reaches $3,000.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $2,000 Eligible Expense, then your child incurs a $400 Eligible Expense, and then your Spouse incurs a $2,400 Eligible Expense. The Eligible Expenses of all family members add up to $4,800. As a result, your $3,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $2,400 expense, the first $600 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

**Coinsurance**

Once you have met your Out-of-Network annual Deductible, you and the HDHP share in the cost of medical care and services through Coinsurance. The HDHP pays 70% and you pay 30% of the R&C Fee for most Covered Services. (See “Reasonable and Customary Fees” below for more information.)

**Reasonable and Customary Fees**

Reasonable and Customary (R&C) Fees are estimates of the typical charges for similar medical care and services within a specific geographic area. Under the HDHP, the R&C Fee is the amount that the HDHP will consider for payment of an Out-of-Network Medically Necessary expense.

If your provider charges more than the R&C Fee, the actual amount above R&C Fees cannot be applied toward your annual Deductible. In addition, the Out-of-Network portion of the HDHP’s Coinsurance will cover 70% of the R&C Fee only; you will be responsible for your share of the Coinsurance, plus any amount in excess of the R&C Fees.

Please note: If you receive care and services In-Network, the fees charged by Participating Providers generally will not exceed the R&C Fee.

For example, suppose your provider charges $1,000 for a surgical expense, and the R&C Fee is $900. Assuming you have met your annual Deductible, your Out-of-Network benefits will pay 70% of the $900 R&C Fee, or $630. You will pay the remaining 30% of the $900 R&C Fee, or $270, plus the $100 difference between the R&C Fee and the actual charge. Your total out-of-pocket expense will be $370.
Annual Out-of-Pocket Maximum
The HDHP Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maximums Cross-Apply In-Network and Out-of-Network. For example, if you incur $700 toward your Out-of-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the In-Network Annual Out-of-Pocket Maximum, and vice versa.

Please note: Amounts in excess of R&C Fees and penalty amounts, such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

Individual Annual Out-of-Pocket Maximum
The individual Annual Out-of-Pocket Maximum for Out-of-Network services under the HDHP is $8,000 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

If you have You Only coverage, once your Out-of-Network out-of-pocket expenses reach the individual maximum, the HDHP will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses incurred by that individual for the rest of the Calendar Year.

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the individual Annual Out-of-Pocket Maximum does not apply to you or your Qualified Dependents.

Family Annual Out-of-Pocket Maximum
If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the family Annual Out-of-Pocket Maximum for Out-of-Network services under the HDHP is $16,000 per Calendar Year. The family maximum will be met when any combination of eligible Out-of-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit.

The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your Out-of-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the Program will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

Maximum Lifetime Benefit for Infertility Treatment
There is an Out-of-Network Maximum Lifetime Benefit of $10,000 for infertility treatment that Cross- Applies with the $20,000 In-Network Maximum.

For example, suppose you elect to receive infertility treatment In-Network and the HDHP pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the Program will pay up to an additional:

- $12,000 for In-Network treatment for a total of $20,000, the In-Network Maximum Lifetime Benefit; or
- $2,000 for Out-of-Network treatment which, when Cross- Applied with the $8,000 paid In-Network, meets the $10,000 Out-of-Network Maximum Lifetime Benefit.

So, while Out-of-Network treatment will be covered up to the $10,000 Maximum Lifetime Benefit, that maximum may Cross-Apply (and reduce that maximum) from treatment received In-Network.

Prescription Drug expenses for infertility treatment have a separate lifetime maximum that does not count toward the HDHP's infertility treatment Maximum Lifetime Benefit. Under the HDHP’s Prescription Drug coverage, there is a $6,000 lifetime maximum for infertility Prescription Drugs (covered In-Network only). Infertility Prescription Drugs do not count toward the HDHP’s lifetime maximum benefit of $20,000 In-Network/$10,000 Out-of-Network. Drugs purchased at a non-participating pharmacy do not apply.
Covered Services
The HDHP covers a wide variety of services as long as the services are Medically Necessary. After you meet the annual Deductible, Out-of-Network care and services are covered at 70% of the R&C Fee. The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

Out-of-Network care and services include, but are not limited to:

Preventive Care
You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at www.cigna.com/prudential to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Out-of-Network Preventive Care services are covered at 70% of R&C Fees after you meet the annual Deductible. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations (including travel immunizations);
- Colonoscopies (including related services);
- Adult routine physicals:
  - X-ray and lab services are covered at 70% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;
- Well-woman care:
  - Anemia screening on a routine basis for pregnant women;
  - Bacteriuria urinary tract or other infection screening for pregnant women;
  - For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
  - Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;
  - Breast cancer mammography screenings every one to two years for women over age 40;
  - Breast cancer chemoprevention counseling for women at higher risk;
  - Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
  - Cervical cancer screening (Pap-tests) for sexually active women;
  - Chlamydia infection screening for younger women and other women at higher risk;
— Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;

— Domestic and interpersonal violence screening and counseling for all women;

— Folic acid supplements for women who may become pregnant;

— Gestational diabetes screening;
  — For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  — Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;

— Gonorrhea screening for all women at higher risk;

— Hepatitis B screening for pregnant women at their first prenatal visit;

— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;

— Human Papillomavirus (HPV) DNA testing;

— Osteoporosis screening for women over age 60 depending on risk factors;

— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

— Sexually transmitted infection (STI) counseling for sexually active women;

— Syphilis screening for all pregnant women or other women at increased risk;

— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and

— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 70% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician's office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.

**Office Visits**

- Non-preventive x-ray and lab services;

- Office Visits (PCP and Specialists) for purposes other than Preventive Care;

- Maternity care:
  — Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;

- Physical, occupational and speech therapy Office Visits (up to 90 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum; this maximum is combined for all therapies):
— Includes cognitive therapy and cardiac and pulmonary rehabilitation; and

— **Please note**: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

- Chiropractic care (up to 60 days per Calendar Year; the day maximum Cross-Applies In-Network and Out-of-Network); and

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**

- Surgery (Inpatient and Outpatient);

- Semi-private room and board at the Hospital;

- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);

- Pre-admission testing;

- Outpatient facility and supplies;

- Physical, occupational and speech therapy in a Hospital setting (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  
  — **Please note**: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

- Ambulance services if Medically Necessary; and

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**

- Delivery care and service at a Hospital or birthing center;

- Skilled nursing facility (up to 60 days per Calendar Year Out-of-Network; the maximum Cross-Applies In-Network and Out-of-Network);

- Home Health Care (up to 100 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum):
  
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and

  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:

— Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

— Home health aid services;

— Physical, occupational or speech therapy by a qualified therapist;

— Dietary counseling;
— Medical social services;
— Medical supplies, drugs and medicines prescribed by a physician;
— Lab services (provided by or for a Home Health Care agency); and
— Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

— Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;
— Services that do not require the technical skills of a medical, Mental Health or dental professional;
— Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;
— Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
— Transportation services;
— Services and supplies not Medically Necessary; and
— Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.

If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

• Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

• Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $10,000 Out-of-Network lifetime maximum, which Cross- Applies In-Network and Out-of-Network):
  — Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum and are not covered Out-of-Network. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits Under the HDHP” beginning on page 61 for more information;
  — Infertility procedures are covered if:
    — A female member is unable to conceive or produce conception after:
• One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;

• Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or

• At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);
  
  − The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, an infertility specialist and the physician who diagnosed the member as infertile;
  
  − The procedures are done while not confined in a Hospital or any other facility as an Inpatient;
  
  − The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
  
  − Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;
  
  − The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and
  
  − The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

• Durable medical equipment (for example, crutches, wheelchairs, braces);

• Office Visits, Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the HDHP or for surgical removal of tumors);

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and

• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:
  
  — Preventive counseling visits (maximum of eight visits per 12 months);
  
  — Treatment visits; and
  
  — Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

  — For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;
• Abdominoplasty;
• Panniculectomy;
• Redundant skin surgery;
• Removal of skin tags;
• Craniosacral/cranial therapy;
• Prolotherapy;
• Transportation services;
• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);
• Removal of an implant that alters the appearance of the body (such as breast or chin implants);
• Orthopedic footwear;
• Footwear to accommodate a diabetic condition;
• Surgical treatment of varicose veins;
• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;
• Home uterine activity monitoring;
• Residential Treatment Centers; and
• Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).

For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**

You must file a claim form for all Out-of-Network care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses. You will receive your claim reimbursement following the receipt and approval of your completed form. Claim forms are available on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)), by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

If your claim is denied, you have the right to appeal the decision. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.) You can also contact your health care carrier for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet the deadline, your claim will be denied.

**In Case of Emergency**

If you have a medical Emergency, defined as an illness or injury that could cause serious bodily harm if not treated immediately, you should go to the nearest Hospital emergency room or urgent care facility. You do not have to contact Cigna first to get Emergency care. Once you have the care you need, you should contact your personal physician to arrange for follow-up care.
If you are admitted to the Hospital, benefits are paid at 90% after you meet the annual Deductible as long as you call Cigna member services at 1-888-502-4462 within 48 hours of admission to the Hospital. (See “Precertification Rules” beginning on page 71 for more information.)

<table>
<thead>
<tr>
<th>Emergency Care Benefits At-A-Glance</th>
<th>Retiree Medical Program E – HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Program pays 90% after annual Deductible is met</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>Program pays 90% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for a true Emergency)</td>
<td>Program pays 90% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for routine or non-Emergency care)</td>
<td>Not covered*</td>
</tr>
</tbody>
</table>

* Ground ambulance support is covered if Medically Necessary, such as for transporting a patient from one Hospital to another. Contact Cigna for details.

**Prescription Drug Benefits Under the HDHP**

If you are enrolled in the HDHP, you will not participate in the Retiree Prescription Drug Program administered by Express Scripts. Instead, Cigna will partner with Express Scripts to administer your Prescription Drug benefits under the HDHP. As you incur Prescription Drug expenses, the amounts will accumulate toward your annual Deductible and Annual Out-of-Pocket Maximum under the HDHP with Cigna. You must purchase Prescription Drugs through the Express Scripts network of participating retail pharmacies or use the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

First, you must meet the HDHP’s annual Deductible. Then, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar minimums and maximums as the table below illustrates.

<table>
<thead>
<tr>
<th>Prescription Drugs Administered by Express Scripts</th>
<th>Retiree Medical Program E – HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>After the HDHP annual Deductible is met, you pay 25% Coinsurance, subject to a $5.00 minimum and a $20.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>After the HDHP annual Deductible is met, you pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
</tbody>
</table>

Footnotes continue on page 62

The HDHP (in partnership with Express Scripts) covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 64.
If you are covering one or more Qualified Dependents, the family annual Deductible must be satisfied before Coinsurance begins.

At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table on page 61, you will pay the lower amount.

<table>
<thead>
<tr>
<th>Other Important Features</th>
<th>Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility Drugs (Oral and Injectables)</td>
<td>$6,000 Maximum Lifetime Benefit (this limit is combined for retail and the Express Scripts Pharmacy home delivery prescriptions)</td>
</tr>
</tbody>
</table>

As you incur Prescription Drug expenses, the amounts will accumulate toward your annual Deductible and Annual Out-of-Pocket Maximum under the HDHP. You will receive an identification card from Express Scripts (your identification card may refer to Medco) to present to the pharmacist when filling prescriptions; this card is different from the identification card you will receive from Cigna to use for your applicable medical expenses.

The Pharmacy Network

Retail pharmacy benefits under the HDHP are available only through participating retail pharmacies that are part of the Express Scripts network. You have access to a network of participating retail pharmacies that offer a high level of service to ensure that you and your Qualified Dependents receive cost-effective, quality pharmaceutical care. When you need to fill a prescription, you can select from a broad range of participating retail pharmacies, including national chains, as well as local pharmacies in your community.

Lists of participating retail pharmacies are available separately from this SPD booklet, at no cost to you. If you need a listing of participating retail pharmacies, several resources are available:

- Visit the Express Scripts website at www.Express-Scripts.com to locate a participating retail pharmacy or contact Express Scripts member services at 1-800-557-0803; or

- Visit the Prudential Benefits Center website (at www.prubenefitscenter.com), where a link to the Express Scripts website is available.

Filling a Prescription

When you or a Covered Qualified Dependent needs to fill a prescription, the HDHP offers you a choice:

- **Visit a participating retail pharmacy:** Through the HDHP, you can visit a participating retail pharmacy, show your Express Scripts identification card (your identification card may refer to Medco) and pay the appropriate Coinsurance (or the appropriate minimum or maximum amount) after you have satisfied the HDHP annual Deductible, for each covered Generic Drug, Brand-Name Preferred Drug or Brand-Name Non-Preferred Drug (up to a 30-day supply). See the table on page 61 for more information. You will likely pay more for a Brand-Name Drug so you may want to ask your doctor to prescribe a Generic Drug (either a Generic Alternative or Generic Equivalent Drug) whenever possible. Generic Alternatives contain different active ingredients than Brand-Name Drugs, but may provide a similar effect when treating a specific condition. FDA-approved Generic Equivalent Drugs contain the same active ingredients as their Brand-Name Drug counterparts and are the same in strength, purity, quality and dosage form. Generic Equivalent Drugs are taken the same way as the Brand-Name Drug counterparts. If a Generic Equivalent Drug is not available, ask your doctor if a Generic Alternative is appropriate for you to take. Generic Alternatives and Generic Equivalent Drugs generally cost less than Brand-Name Drugs.

Express Scripts provides you with an identification card to use at participating retail pharmacies. Your Express Scripts identification card (your identification card may refer to Medco) is also available on your mobile device when you log in to the Express Scripts mobile application ("app"). You can download the app for free when you search for “Express Scripts” from your mobile device app store. Your Express Scripts identification card will indicate to the pharmacist that you have
Prescription Drug coverage. You must show your identification card to the pharmacist at your participating retail pharmacy whenever you purchase Prescription Drugs. If you fail a prescription at a participating retail pharmacy without presenting your Express Scripts identification card, your Prescription Drugs will not be covered and you will be responsible for 100% of the drug cost.

If you choose to purchase Prescription Drugs from a pharmacy that does not participate in the Express Scripts network, your Prescription Drugs will not be covered. You will be responsible for 100% of the cost of drugs purchased at non-participating pharmacies, except in the case of Emergencies.

- **Use the home delivery Prescription Drug program:** Through the Express Scripts Pharmacy, you can order up to a 90-day supply of covered medications for the appropriate Coinsurance (or the appropriate minimum or maximum amount) after you have satisfied the HDHP annual Deductible, for a Generic Drug, a Brand-Name Preferred Drug or a Brand-Name Non-Preferred Drug. See the table on page 61 for more information.

Through the Express Scripts Pharmacy, you can purchase up to a 90-day supply of long-term maintenance medications, typically at a lower cost than what you would pay for three 30-day supplies of the same medication at a participating retail pharmacy. Maintenance medications are drugs taken to help control a chronic health condition, such as high blood pressure, diabetic conditions, arthritis and ulcers. For more information about covered conditions, contact Express Scripts member services.

To order your medication through the home delivery program:

- Fill out a **Health Assessment Questionnaire** and the **Express Scripts Pharmacy Order Form** (included with your Program materials and available at [www.Express-Scripts.com](http://www.Express-Scripts.com));

- Send your completed forms, along with the original prescription from your doctor and payment for your medication. To determine the cost of the prescription and to calculate the amount of Coinsurance required (if you have satisfied your HDHP annual Deductible), visit the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) or call Express Scripts member services at 1-800-557-0803. If you are a first-time visitor to the website, please take a moment to register. Please have your member number available.

  See “*My Rx Choices*” beginning on page 65 for more information about finding available lower-cost options for medications you take on an ongoing basis;

- You can pay by check, e-check, money order or credit card. In most cases, you will receive your medication within 14 days after your order is received; or

- For refills, log in to the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) or the Express Scripts mobile app, or you can use the form included with your last prescription order through the Express Scripts Pharmacy. You can also order your refill by phone by calling 1-800-4REFILL (1-800-473-3455). It is a toll-free number and you can call 24 hours a day, 7 days a week.

For more information about the Express Scripts Pharmacy, call Express Scripts member services at 1-800-557-0803.

**Covered Prescription Drugs**

Prescription Drug coverage under the HDHP (both the retail and home delivery programs) includes most medications prescribed by a licensed health care provider. If you are uncertain whether or not a drug is covered, contact Express Scripts member services at 1-800-557-0803 or log in to the Express Scripts website (at [www.Express-Scripts.com](http://www.Express-Scripts.com)), select “Price a medication” from the drop-down menu under “Manage Prescriptions” and follow the prompts.

Covered Prescription Drugs under the HDHP include, but are not limited to:

- AIDS-related drugs;

- Anabolic steroids (not for athletic use);
• Compounds containing at least one Federal Legend Drug;
• Contraceptive devices;
• Diaphragms;
• Emergency allergy kits;
• Federal Legend Drugs;
• Glucose test strips;
• Growth hormones;
• Imitrex (sumatriptan);
• Immunosuppressants;
• Infertility drugs (subject to a Maximum Lifetime Benefit—please see the “Other Important Features” table on page 62 for more information);
• Insulin (needles and syringes);
• Isotretinoin;
• Lancets;
• Oral contraceptives;
• Prenatal prescription vitamins;
• Prescription and over-the-counter smoking cessation products;
• Prescription vitamins;
• Retin-A/Avita/Altinac cream (non-cosmetic uses); and
• Self-administered injectable drugs.

Preventive Medications
The HDHP covers the following preventive medications—both prescription and over-the-counter (OTC)—at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy.

• Aspirin—an OTC product for ages 45 to 79 for cardiovascular protection;
• Contraceptives—most FDA-approved products, including:
  — Generic oral contraceptives (hormonal). Brand-name products with a generic equivalent are not covered at 100% unless your health care provider determines that the generic is medically inappropriate;
  — OTC contraceptives, including emergency contraceptives, with a prescription through age 50;
  — Single-source brand-name oral contraceptives that do not have a generic equivalent available;
  — Single-source brand-name transdermal patches and vaginal ring;
  — Brand-name barrier contraceptives such as the diaphragm that do not have a generic equivalent available;
Brand-name implanted devices and contraceptives such as Mirena IUD that do not have a generic equivalent available; and

Single-source brand-name injectable contraceptive medications (for example, Depo-Provera) that do not have a generic equivalent available;

- Folic acid—OTC doses of 400 to 800 mcg/day for women through the age of 50 who are pregnant or who are planning to become pregnant;
- Fluoride—a prescription product for children through the age of five to prevent dental cavities;
- Iron supplements—an OTC product for children less than one year of age;
- Smoking cessation products—some OTC and some prescription products for members age 18 and older (limited to up to 180 days of therapy per year), including:
  - Nicotrol NS;
  - Nicotrol Inhaler;
  - Zyban;
  - Chantix;
  - Nicorette Gum/Lozenge; and
  - Nicotine Transdermal System;
- Vitamin D supplements for members age 65 and older (effective January 1, 2014); and
- Bowel preparation for colonoscopy screening (effective January 1, 2014).

**Express Scripts’ National Preferred Formulary**

Visit the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) to find out if a Prescription Drug is included on the Express Scripts National Preferred Formulary and to find cost information for specific Prescription Drugs based upon the HDHP design.

A formulary is a list of Prescription Drugs that pharmacy benefit managers, like Express Scripts, develop based on each drug’s effectiveness in terms of treatment and cost. The Express Scripts National Preferred Formulary includes a broad list of prescription medications. However, not all drugs are included on this preferred list. If your prescription medication is not on the preferred list, you may wish to discuss alternatives with your physician.

To determine if a Prescription Drug is included on the formulary, log in to the Express Scripts website (at [www.Express-Scripts.com](http://www.Express-Scripts.com)), select “Price a medication” from the drop-down menu under “Manage Prescriptions” and follow the prompts. You may also call Express Scripts member services at 1-800-557-0803 to speak with a member services representative to obtain this information.

Please note that the Express Scripts National Preferred Formulary may include certain Prescription Drugs that are excluded from coverage under the HDHP. The inclusion of a medication on the Express Scripts National Preferred Formulary is not a guarantee of coverage under the HDHP—the program’s exclusions of specific medications still apply.

**My Rx Choices**

The My Rx Choices prescription savings program is offered by Express Scripts, your Prescription Drug benefit manager. My Rx Choices is an online prescription savings tool designed to help you find potential lower-cost options for Prescription Drugs available under your program.

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Note that My Rx Choices presents options for long-term maintenance medications (medications that you take on an ongoing basis) only.
To use *My Rx Choices*, follow these steps:

1) Log in to *My Rx Choices* ([at www.Express-Scripts.com/choices](http://www.Express-Scripts.com/choices)). If you have not yet registered as a member on the Express Scripts website, you will need to register before you can access *My Rx Choices*. Please have your Express Scripts identification card (your identification card may refer to Medco) handy. If you prefer to access *My Rx Choices* by telephone, call 1-800-319-7750. **Please note:** The telephone number for *My Rx Choices* is different from the Express Scripts member services telephone number you use for other questions; and

2) Check to see if there are any lower-cost options available for the medications you take on an ongoing basis.

*My Rx Choices* shows you any available lower-cost options, including Generic Drugs, and how much you could save by switching to a lower-cost medication. Please note that *My Rx Choices* does not show possible OTC alternatives. You will need to speak with your physician regarding any OTC alternatives that may be appropriate for you.

You also have the opportunity to print a report of your available lower-cost options so that you can review them with your physician. There are forms included to make it easy for your physician to submit a new prescription to the Express Scripts Pharmacy, your home delivery pharmacy.

Your doctor knows which medications are right for you but he/she may not know how much they cost. *My Rx Choices*, offered by Express Scripts, provides you with lower-cost options available under your program so that you and your doctor can make the most informed decisions based on health and cost. **No prescription is ever changed without your doctor’s approval.**

You can also access *My Rx Choices* from your mobile device when you download the Express Scripts mobile app for free, enabling you to see whether there are lower-cost options under your program while in the doctor’s office.

If you are looking for a medication on *My Rx Choices* that you take regularly and can’t find it, or if you are taking a Prescription Drug that is not a long-term maintenance medication and you would like to determine if there are potential alternatives, call Express Scripts member services at 1-800-557-0803.

For pertinent details and disclosures regarding *My Rx Choices*, visit the website ([at www.Express-Scripts.com/choices](http://www.Express-Scripts.com/choices)).

**Pre-Authorization for Prescription Drugs**

Prudential is committed to keeping the cost of your Prescription Drugs down while providing you with the coverage you need. With this goal in mind, Express Scripts uses a set of coverage review programs to determine how the HDHP will cover certain Prescription Drugs.

These programs fall under two categories: coverage review and review for the amount of coverage. Programs under both categories may review some or all of the following information:

- The diagnosis or condition for which the Prescription Drug is being prescribed;
- Dosing and/or duration of therapy;
- Patient drug history for prior and simultaneous medication use; and
- Age and gender of the patient.

**Coverage Review**

For some Prescription Drugs, you must obtain pre-authorization through the coverage review process in order to obtain coverage. A coverage review is performed to determine whether your use of the drug qualifies for coverage under the HDHP’s current criteria. You, your doctor or your pharmacist may request a coverage review by calling Express Scripts member services at 1-800-753-2851. **Please note:** The telephone number for coverage review is different from the Express Scripts member services telephone number you use for other questions.
The following drugs or drug categories will require a coverage review with Express Scripts and your doctor. This list is subject to change:

- AIDS-related drugs (Selzentry);
- Allergy and Asthma agents (Xolair);
- Androgen and Anabolic steroids;
- Anti-Interleukins (Arcalyst, Ilaris);
- Antinflammatory agents (Nuvigil, Provigil);
- Antineoplastic and Immunomodulator agents;
- Antiviral agents (Incivek, Victrelis);
- Appetite suppressants and weight loss therapy;
- Cholesterol lowering agents (Lovaza, Vescepa);
- Chronic obstructive pulmonary disease (COPD) agents (Daliexp);
- Cushing's syndrome related hyperglycemia agents (Korlym);
- Diabetic ulcer agents (Regranex);
- Erythroid stimulants;
- Gastrointestinal agents (Chenodal);
- Growth hormones;
- Hereditary angioedema agents (Firazyr);
- Infertility agents;
- Interferons;
- Miscellaneous dermatological agents (brand tetracyclines, Elidel, Protopic, Retin-A, Tazorac);
- Miscellaneous hormones (Acthar);
- Multiple Sclerosis therapy;
- Myeloid stimulants;
- Neurological agents (Xenazine);
- Osteoarthritis agents (Solaraze);
- Osteoporosis agents (Forteo);
- Pain management (fentanyl, Lidoderm);
- Phenylketonuria agents (Kuvan);
- Prostate cancer GnRh analogs;
- Psoriasis therapy (Stelara);
Pulmonary agents (Kalydeco);

Pulmonary Arterial Hypertension agents; and

Rheumatological agents.

If your claim is denied after consideration of the information in Express Scripts’ records, you have the right to appeal the decision. Information on how to request an appeal will be included in the decision letter that you receive. See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information on benefit claims and how to appeal a denied benefit claim.

**Review for the Amount of Coverage**

The HDHP provides coverage for a quantity of medication and duration of treatment sufficient to meet the needs of most patients. A review for the amount of coverage is required to determine if a greater quantity of medication or longer course of treatment meets established coverage criteria.

The following drugs or drug categories may require a review for the amount of coverage. This list is subject to change:

- Allergy agents (oral antihistamines and nasal sprays);
- Anti-fungal agents;
- Anti-Influenza agents;
- Antineoplastic and Immunomodulator agents;
- Antiviral agents;
- Asthma agents (short- and long-acting inhalers);
- Chronic obstructive pulmonary disease (COPD) agents;
- Contraceptives—emergency and injectable forms;
- Emergency allergy kits;
- Eye condition medication/agents (Restasis);
- Hypnotics;
- Intranasal steroids;
- Migraine therapy;
- Nausea and vomiting agents;
- Non-sedating antihistamines; and
- Ulcer therapy.

**Requesting a Coverage Review or a Review for the Amount of Coverage**

If you submit a prescription to a participating retail pharmacy for a medication that requires a coverage review or a review for the amount of coverage, you, your doctor or your pharmacist may initiate the review by calling Express Scripts member services at 1-800-753-2851. Please note that the telephone number for coverage review is different from the Express Scripts member services telephone number you use for other questions.
Your doctor will be sent a **Coverage Management Review Fax Form** to fill out and send back to Express Scripts at the fax number indicated on the form. When you use the Express Scripts Pharmacy home delivery service, Express Scripts will call your doctor to start the coverage review process. Express Scripts will send you and your doctor a letter confirming whether or not coverage is approved (usually within two business days of receiving the necessary information).

If coverage is approved, you will pay your normal Coinsurance (subject to appropriate minimum and maximum dollar amounts) for the Prescription Drug.

If coverage is not approved, you will be responsible for the full cost of the Prescription Drug at a participating retail pharmacy. While the review process is pending, if you choose to fill the prescription rather than wait for the completion of the review process, you will be responsible for the full cost of the medication. You have the right to appeal the decision. Information on how to request an appeal will be included in the decision letter that you receive. See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information on benefit claims and how to appeal a denied benefit claim.

To have your claim for benefits considered, you need to file your claim within one year from the date your claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim.

**Prescription Drug Expenses Not Covered**

The list of drugs not covered under the HDHP includes, but is not limited to:

- Nutritional/dietary supplements;
- OTC drugs and medications (except non-prescription insulin and certain OTC preventive medications prescribed by a physician that are covered at 100%, as described beginning on page 64) and Prescription Drugs that have an OTC equivalent available, such as Zantac;
- Injectable drugs that are not self-administered;
- Non-Federal Legend Drugs;
- Drugs for the treatment of erectile dysfunction, such as Viagra;
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only; and
- Emergency contraceptives that are available OTC (except OTC emergency contraceptives prescribed by a physician that are covered at 100%, as described beginning on page 64).

**Please note:** The Express Scripts National Preferred Formulary may exclude some medications from select drug categories from coverage under Prudential’s Retiree Prescription Drug Program administered by Express Scripts.

If you are not sure whether or not a drug is covered, call Express Scripts member services at 1-800-557-0803.

**Additional Discounts Available Through Express Scripts**

Another benefit of having your program administered by Express Scripts is a feature that offers you a discount on prescription medications that are not covered by the HDHP. To take advantage of these discounts, order your out-of-program prescriptions, such as Propecia, Viagra and Renova, through the Express Scripts Pharmacy home delivery service. You do not have to sign up for anything to get these discounts.

For your convenience, you can order your discounted medications using the same home delivery prescription form and envelope that you would normally use to order home delivery prescriptions. Be sure to include the full payment for your discounted medications when you send in your order so it can be processed.

You can check the prices for these discounted medications by visiting the Express Scripts website at [www.Express-Scripts.com](http://www.Express-Scripts.com) or by calling Express Scripts member services at 1-800-557-0803.
Filing Claims for Prescription Drugs

When you use your identification card at a participating retail pharmacy or when you use the Express Scripts Pharmacy home delivery service, you do not need to complete a claim form—a claim will be filed automatically on your behalf.

In the event of an Emergency, if you are unable to visit a participating retail pharmacy, you will need to pay in full for a prescription and then file a claim with Express Scripts for reimbursement. You can request a reimbursement claim form by contacting Express Scripts member services at 1-800-557-0803 or by visiting the Express Scripts website (at www.Express-Scripts.com). Instructions on how to fill out the form and where to send it are printed on the back of the claim form.

Remember that prescriptions purchased at non-participating pharmacies are not covered by the HDHP, except in the event of an Emergency. If you have a prescription filled at a pharmacy that does not participate in the Express Scripts network, you will not be reimbursed by the HDHP. You will be responsible for the full cost of the prescription, except in the event of an Emergency.

The submission of your prescription to the pharmacy does not constitute a claim for benefits under the claims procedures outlined in this SPD booklet. If, after submitting your prescription to the pharmacy, you feel that you were not provided with the benefits you are entitled to under the Program, and you want to make a claim for benefits, you must file a claim form with Express Scripts member services. The claim form should be mailed to:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063

If your claim is denied, you have the right to appeal the decision (see “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information). You may also contact Express Scripts member services at 1-800-557-0803 for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet this deadline, your claim will be denied.

Coordination of Benefits for Prescription Drugs

Under the Coordination of Benefits provision, the HDHP will coordinate with another program to pay benefits up to 100% of Covered Charges for Prescription Drugs but no more than the percent it would normally pay for Covered Charges if the HDHP were the only payer.

For example, suppose your Spouse is covered under his/her employer’s program and that program pays for Brand-Name Prescription Drug benefits based on 60% Coinsurance. You cover your Spouse as a Qualified Dependent under the HDHP and you have already satisfied your annual Deductible, but have not yet reached your Annual Out-of-Pocket Maximum. Your Spouse fills a prescription at a participating retail pharmacy for a Brand-Name Preferred Drug that costs $300. Assuming your Spouse has met any annual Deductible under his/her employer’s program, his/her employer’s program would pay $180 toward Covered Expenses. Your Spouse would be responsible for the remaining $120.

Your Spouse could then submit a claim for reimbursement to the HDHP. Your Spouse’s costs for the Brand-Name Preferred Drug would have been $45 under the HDHP (25% x $300 = $75, subject to a $45 maximum), if it were the primary program. The HDHP would have paid $255 ($300 – $45) if it were the primary program. Since your Spouse has already received benefits of $180 under his/her employer’s program, the HDHP would reimburse your Spouse $120 ($300 – $180 = $120) because the remaining cost of the drug, $120, is less than the $255 the HDHP would have paid if it was the only program. The result of the Coordination of Benefits provision is that your Spouse had 100% of the Covered Charge paid for between the two programs.

Prescriptions filled at pharmacies that do not participate in Express Scripts’ network are not covered by the HDHP, except in the event of an Emergency. If your Spouse used a non-participating pharmacy, your Spouse’s Prescription Drug purchase would not be eligible for Coordination of Benefits.
**Please note:** The HDHP follows a non-duplication of benefits provision for all services other than Prescription Drug coverage. See the “Non-Duplication of Benefits Provision” section beginning on page 183 for more information.

**Precertification Rules**

Precertification is an important tool in managing the quality and expense of Inpatient Hospital and facility admissions and certain Outpatient procedures and tests. You or your provider must call the toll-free number listed on your identification card to precertify Hospital admissions and certain Outpatient procedures and tests, as required by the HDHP (see also “In Case of Emergency” beginning on page 60 for more information). Failure to do so may affect your benefits. In an Emergency, seek care immediately, then call your physician within 48 hours for further assistance and directions on follow-up care.

<table>
<thead>
<tr>
<th>Precertification Rules At-A-Glance</th>
<th>Retiree Medical Program E – HDHP</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
</tr>
<tr>
<td>Who should call</td>
<td>You or your Participating Provider</td>
</tr>
<tr>
<td>Where to call</td>
<td>Cigna 1-888-502-4462</td>
</tr>
<tr>
<td>When to call</td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
</tr>
<tr>
<td></td>
<td>or</td>
</tr>
<tr>
<td></td>
<td>Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
</tr>
<tr>
<td>If you call to precertify, and care is determined not Medically Necessary</td>
<td>No coverage</td>
</tr>
<tr>
<td>If you do not call to precertify, but care is Medically Necessary</td>
<td>20% reduction in Eligible Expenses</td>
</tr>
<tr>
<td>If you do not call to precertify, and care is not Medically Necessary</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

**For In-Network Care**

You or your Participating Provider must contact Cigna patient management to request Precertification of your care.

**For Out-of-Network Care**

For Out-of-Network care, you must call Cigna member services at 1-888-502-4462 to precertify care. When you call, you will speak with an experienced consultant who will determine the medical necessity of your admission and length of stay, and can advise you of alternative options that may be appropriate.
If you do not call to precertify, the Eligible Expenses will be reduced by 20%. If your admission, length of stay, surgical procedure or test is not considered Medically Necessary, no benefits will be paid.

The following Outpatient procedures and services require Precertification under the HDHP:

- All sinus surgery;
- Electroconvulsive therapy;
- Hysterectomy;
- Lumbar myelography;
- MRI – brain;
- MRI – lumbar;
- MRI – musculoskeletal;
- MRI – thoracic;
- Pelvic laparoscopy;
- PET scan;
- Psychological/neuropsychological testing of more than six hours;
- Outpatient detoxification involving methadone or suboxone;
- Intensive or structured Outpatient programs; and
- Biofeedback/neurofeedback.

This list is not all-inclusive and is subject to change. You should call Cigna member services at 1-888-502-4462 to determine whether your procedure requires Precertification.

In-Network Benefits for Special Situations
The HDHP has provisions for special health care situations to ensure that you can get In-Network benefits whenever possible.

Medical Care While Traveling

Emergency Care
In an Emergency situation—whether you are traveling within or outside of your network area—you or your family should call 911 or seek treatment at the nearest Emergency facility or urgent care facility. If you are enrolled in the HDHP, you, your family or your physician should contact Cigna member services at 1-888-502-4462 within 48 hours of receiving Emergency care.

Non-Emergency Care
If medical care is necessary, but not an Emergency and you are enrolled in the HDHP, you should contact Cigna member services to find out if there is an affiliated network provider in the area. If so, Cigna can refer you to Participating Providers to ensure that you receive In-Network benefits. If not, you may see a non-Participating Provider. However, services will be reimbursed at the Out-of-Network level of benefits.

If you have a chronic condition, contact your personal physician before traveling to discuss any care requirements while you are away from home.
Medical Care for Students Outside the Network Service Area

If you are enrolled in the HDHP, you should contact Cigna member services to determine if there is a network in the area where your child attends school. If a local network is available, your child may use any provider in that network. Your child will receive the full range of In-Network benefits. If your child is not in a network area, follow the rules described under “Medical Care While Traveling” on page 72.

Centers of Excellence Programs

The HDHP includes a “Centers of Excellence” Program, which provides access to medical facilities and staff who are experienced in specialty procedures such as organ and tissue transplants, cardiac bypass surgery, angioplasty and brain/spinal cord injuries. The Program pays for Medically Necessary services and supplies involved with these procedures at the same benefit level as other services.

Cigna LIFESOURCE Organ Transplant Network

Cigna LIFESOURCE Organ Transplant Network is a network of nationally recognized medical centers that can provide the most appropriate care for members requiring organ or tissue transplants (including heart, heart/lung, lung, liver, kidney/pancreas and allogeneic bone marrow transplants). The Cigna LIFESOURCE Organ Transplant Network for Kids is also available to care for the special needs of children and their families. The HDHP covers care and services In-Network at the 90% Coinsurance amount after the annual Deductible and Out-of-Network at the 70% Coinsurance amount after the annual Deductible.

Transportation and lodging benefits are covered for the patient and a companion when using a Cigna LIFESOURCE facility. Travel expenses are covered up to a maximum of $10,000 per transplant, In-Network only.

Cigna Healthy Rewards

Through Cigna’s Healthy Rewards program, Cigna offers personalized services, online features and support to participants, including offering discounts on a variety of products and services. Access to Healthy Rewards is available regardless of which Cigna Retiree Medical Program option you enroll in. You can get more information regarding Healthy Rewards through the Cigna custom website for Prudential at www.cigna.com/prudential or by calling Cigna member services at 1-888-502-4462.

Health Savings Account

When you participate in Prudential’s HDHP, you can also elect to establish and contribute to a Health Savings Account (HSA), if you are eligible. The HSA provides an opportunity to fund qualified health care expenses. When you enroll in the HDHP, you may choose to enroll in the Cigna HSA administered by JPMorgan Chase, and make personal payment arrangements. You must enroll in Prudential’s HDHP if you wish to contribute to the Cigna HSA administered by JPMorgan Chase.

IMPORTANT NOTICE: It is the intention of Prudential to comply with Department of Labor guidance set forth in Field Assistance Bulletin No. 2004-1, which specifies that an HSA is not an ERISA plan if certain requirements are satisfied. The Cigna HSA described in this section is not an arrangement that is established and maintained or sponsored by Prudential as your former employer. Rather, the Cigna HSA is established and maintained by the HSA custodian. Your payments can be deposited into the Cigna HSA administered by JPMorgan Chase.

Who Is Eligible to Contribute to the Cigna HSA

If you enroll in Prudential’s HDHP and you reside within the United States, you may be eligible to contribute to the Cigna HSA administered by JPMorgan Chase.

Who Is Not Eligible to Contribute to the Cigna HSA

You are not eligible to contribute to the Cigna HSA administered by JPMorgan Chase if you:

- Reside outside the United States;
• Are enrolled in a different Prudential Retiree Medical Program option or other medical program (for example, through a Spouse’s employer);
• Are enrolled in Medicare Parts A and/or B;
• Are enrolled in Tricare (benefits offered to military personnel);
• Are covered as a dependent under another medical plan, pharmacy program or Flexible Spending Account (FSA) through your Spouse’s employer;
• Are a resident of Puerto Rico or Hawaii; or
• Are claimed as a dependent on someone else’s tax return.

**HSA Features**

HSAs generally have the following features:

• HSA contributions may be made as personal payment arrangements you make to transfer funds from your checking account to your HSA;

• Investment income on HSA funds is tax-deferred for Federal tax purposes;

• All HSA withdrawals used exclusively for eligible health care expenses for you and your Spouse and your Qualified Dependents, as defined by the Federal government, are tax-free. Please note the following:
  — Purchases of over-the-counter (OTC) medications are not reimbursable under the HSA. Exceptions are OTC medicines prescribed by a doctor and insulin; and
  — Expenses for children who are not your “Qualifying Child” or “Qualifying Relative” under Section 152 of the Code, without regard to the requirement that the child has gross income less than the exemption amount (the “income limitation”) or whether your child has dependents, cannot be reimbursed from the HSA;

• All unused HSA balances carry over to the following Calendar Year. There is no maximum carry-over provision associated with these accounts;

• HSAs are “portable,” meaning that if your participation in the HDHP ends, you have 100% ownership and rights to your HSA balance; and

• If you use your HSA funds to pay for non-qualified health care expenses, the amount distributed from your HSA for the non-qualified medical expense will be subject to income tax and a 20% excise tax.

Because HSAs offer a number of potential financial benefits, the Federal government requires that they be offered only in conjunction with a high deductible medical benefit. **In order to elect to contribute to the Cigna HSA administered by JPMorgan Chase, you must enroll in Prudential’s HDHP. You may enroll in the HDHP and choose not to participate in the Cigna HSA. But if you do want to participate in the Cigna HSA administered by JPMorgan Chase, you must first enroll in Prudential’s HDHP.**

**Please note:** Many financial institutions offer HSA products to their customers. Any individual who is enrolled in a high deductible health plan can choose to open an HSA through one of these other providers, subject to those providers’ HSA terms and conditions. If you choose to open an HSA other than the Cigna HSA administered by JPMorgan Chase, you must make such arrangements independently, and outside the Prudential enrollment process.

If you are enrolling in the Cigna HSA and wish to contribute to your Cigna HSA through personal payment arrangements, you will need to call Cigna member services at 1-888-502-4462.
HSA Contributions

If you have individual HDHP coverage with Prudential, the annual HSA contribution limit for 2013 is $3,250 and the limit for 2014 is $3,300. If you cover yourself and others under the HDHP, the annual HSA contribution limit is $6,450 for 2013 and $6,550 for 2014. (The limits are subject to change in future years.) You are eligible to contribute up to the annual contribution limit regardless of the number of months during which you are covered by an HDHP. That is, if you enroll in the Cigna HSA for only half of the Calendar Year, you are still eligible to contribute up to the annual limit. In order to avoid income tax withholding and an additional 10% tax penalty for contributing the entire annual maximum amount mid-year, you will need to remain HSA-eligible for the remainder of the Calendar Year (through December 31) and the entire 12-month period following the Calendar Year. Contact Cigna member services at 1-888-502-4462 or your HSA institution for more information about making mid-year contributions.

Higher “catch-up” contributions are allowed for individuals age 55 and older; these individuals can contribute an additional $1,000 for 2013 and 2014 (subject to change in future years). As the account holder, it is up to you to make sure that contributions to your HSA do not exceed the annual maximum limits or you will be subject to income tax withholding and an excise tax penalty for amounts that exceed the annual maximum limit.

You may generally roll over balances between HSAs on a tax-free basis. Rollovers do not affect your annual HSA contribution limits. To initiate a rollover, contact Cigna member services at 1-888-502-4462.

IRS Circular 230 disclosure: Neither Prudential nor its representatives are authorized to provide tax or legal advice or financial advice on behalf of the Program. Any tax information provided is not intended or written to be used, and cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code. You are encouraged to consult with your tax, financial and/or legal advisors for advice regarding your particular situation.

Portability

If your participation in the Retiree Medical Program E – HDHP ends, you have 100% ownership and rights to your HSA balance and you may keep your Cigna HSA open. You must notify Cigna member services at 1-888-502-4462 if you would like to close your Cigna HSA administered by JPMorgan Chase.

HSA Investment Minimum

Once your HSA balance reaches $1,000\(^{10}\), you can begin to take advantage of the investment opportunities available through the Cigna HSA administered by JPMorgan Chase. After you accumulate at least $1,000\(^{10}\) in your cash account, you will have the option to move money from your cash account into an “investment account,” where you can invest in a variety of mutual funds. The initial transfer to the investment account must be at least $1,000\(^{10}\). There is no minimum transfer amount for subsequent transfers. You pay no monthly fee for maintaining the investment account. Prudential pays the monthly maintenance fees for maintaining the investment account for you while you are enrolled in the HDHP. For more information about the investment account and to transfer money from your cash account to an investment account, log on to the Cigna website (at www.mycigna.com), click on the link for “Accounts/View Account Balances,” select “Transaction History,” then click on the Investments tab and then the “Learn About Investments” link. If you have any questions, you also may call Cigna member services at 1-888-502-4462.

HSA Fees

As a personal savings account, your Cigna HSA is subject to certain fees. Some of these fees will be deducted directly from your account monthly or when you execute specific activities. Other fees may be paid by Prudential on your behalf. Please see your Annual Enrollment materials provided during the Annual Enrollment Period or call Cigna member services at 1-888-502-4462 for information about fees associated with the Cigna HSA administered by JPMorgan Chase.

\(^{10}\) $2,000 if your Medical Program coverage is continued under COBRA or COBRA-like coverage.
No HSA Maintenance or Investment Account Fees

Prudential will pay the Cigna HSA monthly account maintenance fees for you, including investment account maintenance fees, as long as you are enrolled in the Retiree Medical Program E – HDHP through Prudential’s benefits program.

You will be responsible for paying the HSA monthly account maintenance fees and investment account maintenance fees if you keep your HSA administered by JPMorgan Chase open and you:

- Elected COBRA continuation coverage; or
- Are an active participant in the Retiree Medical Program and subsequently drop your HDHP coverage (for example, if you become eligible for Medicare and your HDHP participation ends).

You will be responsible for paying all fees associated with any non-Cigna HSA you open and maintain. You may roll over a non-Cigna HSA to the Cigna HSA so Prudential will pay the Cigna HSA monthly maintenance fees and investment maintenance fees.

If You Have Questions About the Cigna HSA

For more information about the Cigna HSA, contact Cigna member services at 1-888-502-4462 with any questions related to your HSA contributions, using your HSA debit card to access your HSA funds, other HSA transactions or your HSA investments.

The HSA is not a Plan; it is an individual savings account. The terms of the Cigna HSA are comprehensively disclosed in the HSA Custodial Agreement—which each Cigna HSA account holder must accept before opening an HSA. Call Cigna member services at 1-888-502-4462 if you want to review the comprehensive Cigna HSA terms that are included in the Cigna HSA Custodial Agreement.
Retiree Medical Program E – CDHP 80

Retiree Medical Program E – Consumer Directed Health Program 80 (CDHP 80) provides non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents with a full range of health care services. Under the CDHP 80, you may choose health care services from Participating Providers—doctors, Hospitals and health care facilities that have agreed to provide Covered Services at reduced or Negotiated Fees—or you may go Out-of-Network to any health care provider you choose. When you use an Out-of-Network provider, you generally pay a higher cost for services than when you use a Participating Provider. You must satisfy an annual Deductible before the CDHP 80 will pay for most In-Network and Out-of-Network health care expenses. The CDHP 80 includes a Health Fund for you to use in paying for current health care expenses.

The CDHP 80 is administered by Cigna HealthCare (Cigna).

If you have questions regarding your benefits, please contact Cigna member services or visit the Cigna custom website for Prudential:

- Cigna member services:
  Telephone: 1-888-502-4462
  Website: www.cigna.com/prudential

The CDHP 80 is available to all non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents, regardless of where you live, except to those who reside in Hawaii, where the CDHP 80 is not available. Access to Cigna providers varies by location and may be limited in some areas. You should check Cigna’s Participating Providers to ensure you have adequate access to providers before enrolling in the CDHP 80 by going to the Cigna custom website for Prudential or by calling Cigna member services (contact information is listed above).

You can also visit the Prudential Benefits Center website at www.prubenefitscenter.com to find Participating Providers; or call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, to find out which programs are available to you.

How the Program Works

<table>
<thead>
<tr>
<th>Retiree Medical Program E – CDHP 80&lt;sup&gt;1&lt;/sup&gt; At-A-Glance</th>
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</thead>
<tbody>
<tr>
<td><strong>Annual Deductible&lt;sup&gt;2&lt;/sup&gt;</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Annual Deductible applies to both In-Network and Out-of-Network care</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum&lt;sup&gt;2&lt;/sup&gt;</strong> (includes annual Deductible)</td>
</tr>
<tr>
<td>$4,000 per individual, $8,000 per family</td>
</tr>
<tr>
<td>Please note that the Health Fund helps to offset a portion of your Annual Out-of-Pocket Maximum</td>
</tr>
<tr>
<td><strong>Annual Health Fund Allocation</strong> (helps satisfy the annual Deductible)</td>
</tr>
<tr>
<td><strong>Annual Health Fund Limit</strong></td>
</tr>
<tr>
<td><strong>Preventive Care&lt;sup&gt;3&lt;/sup&gt;</strong></td>
</tr>
<tr>
<td>Table and footnotes continue on page 78</td>
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</tbody>
</table>
Retiree Medical Program E – CDHP 80

### At-A-Glance

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care and Specialty Care Office Visits</td>
<td>Program pays 80% after annual Deductible is met</td>
<td>Program pays 60% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Program pays 80% after annual Deductible is met</td>
<td>Program pays 60% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Hospital Stays</td>
<td>Program pays 80% after annual Deductible is met</td>
<td>Program pays 60% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>Program pays 80% after annual Deductible is met</td>
<td>Program pays 60% of R&amp;C Fees after annual Deductible is met</td>
</tr>
</tbody>
</table>

*The CDHP 80 is not available in Hawaii.*

*Prescription Drug charges do not apply toward the annual Deductible or the Annual Out-of-Pocket Maximum under the CDHP 80. In addition, amounts in excess of R&C Fees and penalty amounts, such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible or the Annual Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.*

*Preventive Care benefits are subject to applicable age and frequency limits. Please contact Cigna for details.*

### Prescription Drugs

| Retiree Prescription Drug Program Administered by Express Scripts1.2 |
|-------------------------------------------------|------------------|------------------|------------------|
|                                                | Generic          | Brand-Name Preferred | Brand-Name Non-Preferred |
| At Participating Retail Pharmacies              |                   |                   |                   |
| (up to a 30-day supply)                        | You pay 25% Coinsurance, subject to a $5.00 minimum and a $20.00 maximum | You pay 25% Coinsurance, subject to a $25.00 minimum and a $45.00 maximum | You pay 40% Coinsurance, subject to a $40.00 minimum and a $100.00 maximum |
| Through the Express Scripts Pharmacy (home delivery) |                   |                   |                   |
| (up to a 90-day supply)                        | You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum | You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum | You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum |

*Prescription Drug expenses do not apply to the CDHP 80’s annual Deductible or the Annual Out-of-Pocket Maximum, and will not draw down your Health Fund.*

*The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.*

*At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.*

The CDHP 80 offers you the choice of receiving In-Network or Out-of-Network care. In general, when you receive care:

- **In-Network**, you visit doctors and health care facilities that participate in Cigna’s network of Participating Providers. You need to meet the annual Deductible before the CDHP 80 starts to pay a percentage, called Coinsurance, of your covered health care expenses. Each time you need care and services, your Participating Provider provides the services at a Negotiated Rate—aft...
the annual Deductible, the CDHP 80 pays 80% and you pay 20%. You do not need to file claim forms for In-Network care or services. Eligible Preventive Care services are not subject to the annual Deductible and are covered at 100%. If your costs for In-Network care reach the CDHP 80’s Annual Out-of-Pocket Maximum, the CDHP 80 will pay 100% of your Covered Expenses for the rest of the Calendar Year, though Prescription Drug charges still apply; and

- **Out-of-Network**, you can visit any doctor or health care facility. You are responsible for submitting a claim form for reimbursement. You need to meet an annual Deductible amount before the CDHP 80 starts to pay a percentage, called Coinsurance, of your covered health care expenses. The CDHP 80 pays 60% of Reasonable and Customary (R&C) Fees and you pay 40% plus any amount above R&C Fees. If your costs for Out-of-Network care reach the CDHP 80’s Annual Out-of-Pocket Maximum, the CDHP 80 will pay 100% of your Covered Expenses (up to R&C Fees) for the rest of the Calendar Year, though Prescription Drug charges still apply.

The program includes a Health Fund, which will help you meet the annual Deductible. If you do not use all the money in your Health Fund during the Calendar Year, you may carry the remaining balance (up to the applicable limit; see “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning below) into the next Calendar Year to pay for future health care expenses under the CDHP 80 or the CDHP 90.

**The Health Fund**

The Health Fund is a recordkeeping account that is established for each CDHP 80 participant to help pay for current health care expenses.

Your covered medical expenses (for example, office visits, labs, x-rays, hospital charges) will be paid under the CDHP 80, and any eligible out-of-pocket expenses will be automatically paid out of the Health Fund as long as there is an available balance. Your explanation of benefits (EOB) will identify the covered expenses, the portion of those charges that were paid from the Health Fund, the portion for which you are responsible to satisfy the annual Deductible and then the portion paid by the CDHP 80 versus the portion that is your responsibility (Coinsurance).

**How the Health Fund Works**

The Health Fund will be credited each January 1. Participants with You Only coverage will receive a credit of $500 and participants who cover one or more Qualified Dependent(s) (You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage categories) will receive a credit of $1,000.

**If You Use All the Money in Your Health Fund During the Calendar Year**

If you use all the money in your Health Fund during the Calendar Year, you must satisfy the balance of the annual Deductible, after which services will be covered at 80% (In-Network) or 60% of R&C Fees (Out-of-Network) until you reach the CDHP 80’s Annual Out-of-Pocket Maximum ($4,000 for individual coverage or $8,000 for family coverage for In-Network care; $8,000 for individual coverage or $16,000 for family coverage for Out-of-Network care). Once you reach the Annual Out-of-Pocket Maximum, Eligible Expenses are covered at 100%, subject to R&C Fees for Out-of-Network services, for the remainder of the Calendar Year. Your Health Fund will be credited again on the next January 1.

**If You Do Not Use All the Money in Your Health Fund During the Calendar Year**

If you do not use all the money in your Health Fund during the Calendar Year, you may carry the remaining balance into the next Calendar Year to pay for future medical expenses under a Retiree Medical Program E – CDHP option. This carry-over happens automatically. In addition to your carried-over balance, your Health Fund will be credited again on the next January 1.

There is a limit on the amount you can have in your Health Fund annually. The limit is $800 for individual coverage and $1,600 if you cover one or more Dependents. Each year, the amount exceeding this limit will be treated differently depending on whether you have the Credit Approach or the RMSA:

- If you have the Credit Approach, any excess above the limit will be forfeited; or
• If you have the RMSA, any excess above the limit will be transferred to your RMSA on or after April 30 of the new program year.

When you leave the Retiree Medical Program E – CDHP option (for example, by enrolling in a different Retiree Medical Program option or attaining Medicare eligibility):

• If you have the Credit Approach, you will lose any remaining balance in your Health Fund; or

• If you have the RMSA, your remaining Health Fund balance will be transferred to your RMSA after 120 days from the date of your disenrollment from the Retiree Medical Program E – CDHP option.

Please see “Prudential’s Financial Support for Retiree Health Care Coverage Costs” beginning on page 6 for more information about the Credit Approach and the RMSA.

For example, a CDHP 80 participant in the Credit Approach could experience the following Health Fund carry-over scenario:

<table>
<thead>
<tr>
<th>Health Fund Carry-Over Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If You…</strong></td>
</tr>
<tr>
<td>Enrolled in a Retiree Medical Program E – CDHP option in 2013</td>
</tr>
<tr>
<td>Health Fund balance at end of 2013</td>
</tr>
<tr>
<td>2014 Health Fund allocation from Prudential</td>
</tr>
<tr>
<td>2014 Health Fund beginning balance</td>
</tr>
</tbody>
</table>
| As a result of the Health Fund limit, on January 1, 2014, you will have: | • $800 in your Health Fund; and  
• $450 forfeited due to the Health Fund limit |
| 2014 Health Fund usage | $400 |
| Health Fund balance at end of 2014 | $400 |
| 2015 Health Fund allocation from Prudential | $500* |
| 2015 Health Fund beginning balance | Total amount in your Health Fund is $900 ($400 carry-over from 2014 plus $500 Health Fund allocation for 2015) |
| As a result of the Health Fund limit, on January 1, 2015, you will have: | • $800 in your Health Fund; and  
• $100 forfeited due to the Health Fund limit |

* This is only an example. Health Fund allocations from Prudential for future years are subject to change.

A CDHP 80 participant in the RMSA could experience the following Health Fund carry-over scenario:

<table>
<thead>
<tr>
<th>Health Fund Carry-Over Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If You…</strong></td>
</tr>
<tr>
<td>Enrolled in a Retiree Medical Program E – CDHP option in 2013</td>
</tr>
<tr>
<td>Health Fund balance at end of 2013</td>
</tr>
<tr>
<td>2014 Health Fund allocation from Prudential</td>
</tr>
</tbody>
</table>

Table and footnote continue on page 81
### Health Fund Carry-Over Feature

<table>
<thead>
<tr>
<th>If You…</th>
<th>Elect Individual Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 Health Fund beginning balance</td>
<td>Total amount in your Health Fund is $1,250 ($750 carry-over from 2013 plus $500 Health Fund allocation for 2014)</td>
</tr>
<tr>
<td>As a result of the Health Fund limit, on January 1, 2014, you will have:</td>
<td>• $800 in your Health Fund; and • $450 transferred to your RMSA on or after April 30 of the new program year due to the Health Fund limit ($1,250 balance minus the $800 limit)</td>
</tr>
<tr>
<td>2014 Health Fund usage</td>
<td>$400</td>
</tr>
<tr>
<td>Health Fund balance at end of 2014</td>
<td>$400</td>
</tr>
<tr>
<td>2015 Health Fund allocation from Prudential</td>
<td>$500*</td>
</tr>
<tr>
<td>2015 Health Fund beginning balance</td>
<td>Total amount in your Health Fund is $900 ($400 carry-over from 2014 plus $500 Health Fund allocation for 2015)</td>
</tr>
<tr>
<td>As a result of the Health Fund limit, on January 1, 2015, you will have:</td>
<td>• $800 in your Health Fund; and • $100 transferred to your RMSA on or after April 30 of the new program year due to the Health Fund limit ($900 balance minus the $800 limit)</td>
</tr>
</tbody>
</table>

*This is only an example. Health Fund allocations from Prudential for future years are subject to change.*

### If You Enroll During the Calendar Year

If you become a new participant mid-year or you enrolled in the CDHP 80 mid-year due to a Qualified Change in Status, the initial amount credited to your Health Fund will be pro-rated based on your date of enrollment. You will receive the Health Fund allocation based on the quarter during which you join the CDHP 80. All dates within the quarter will be treated equally. During the first quarter, the initial amount credited to your Health Fund account is not reduced. Subsequent quarters are reduced as follows:

- Second quarter reduced by 25%;
- Third quarter reduced by 50%; and
- Fourth quarter reduced by 75%.

### If You Add or Remove a Dependent During the Calendar Year

If you are enrolled in the CDHP 80 with You Only coverage and experience a Qualified Change in Status mid-year in which you change from You Only coverage to You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the amount credited to your Health Fund will change from the individual amount of $500 to the family amount of $1,000, but this increase will be pro-rated based on the date of your Qualified Change in Status. You will receive the increased Health Fund allocation based on the quarter in which your Qualified Change in Status was effective. All dates within the quarter will be treated equally. During the first quarter, the amount credited to your Health Fund account is not reduced. Subsequent quarters are reduced as follows:

- Second quarter reduced by 25%;
- Third quarter reduced by 50%; and
- Fourth quarter reduced by 75%.

If you are enrolled in the CDHP 80 with You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage and experience a Qualified Change in Status mid-year in which you change your You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage to You Only coverage,
the amount credited to your Health Fund will decrease from the family amount of $1,000 to the lesser of: (a) the individual Health Fund amount of $500; and (b) the balance of the Health Fund on the day prior to the Qualified Change in Status.

The following two examples provide clarification for how changing to You Only coverage mid-year affects the Health Fund:

1) You are enrolled in the CDHP 80 with You + Spouse/Qualified Adult coverage. You have a Health Fund balance of $1,000 at the beginning of the Calendar Year. You or your Spouse, or a combination of both you and your Spouse, incur medical claims totaling $250 in February. Your Health Fund will be used to pay the $250, at which point, you will have $750 remaining in your Health Fund. In April, you have a Qualified Change in Status due to divorce, and your coverage changes from You + Spouse/Qualified Adult coverage to You Only coverage. At that time, your Health Fund balance will reduce to $500, which will be available to you for the remainder of the Calendar Year; or

2) You are enrolled in the CDHP 80 with You + Spouse/Qualified Adult coverage. You have a Health Fund balance of $1,000 at the beginning of the Calendar Year. You or your Spouse, or a combination of both you and your Spouse, incur medical claims totaling $750 in February. Your Health Fund will be used to pay the $750, at which point, you will have $250 remaining in your Health Fund. In April, you have a Qualified Change in Status due to divorce, and your coverage changes from You + Spouse/Qualified Adult coverage to You Only coverage. At that time, you have a Health Fund balance of $250, which is already less than the $500 individual amount for the Health Fund, so the Health Fund balance available to you for the remainder of the Calendar Year is $250.

Any Health Fund amount that you may have carried forward from a prior Calendar Year that has not been used as of the date of the change in status, and that remains unused, would still be available to you as long as it does not exceed the applicable limits. If it exceeds the maximum amount you may have in the Health Fund and you elected the Credit Approach, the excess amount will be forfeited on or after April 30 of the new program year. If it exceeds the maximum amount you may have in the Health Fund and you elected the RMSA, the excess amount will be transferred to your RMSA on or after April 30 of the new program year. See “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning on page 79.

**If Your CDHP Enrollment Ends During the Calendar Year**

Your Health Fund balance will continue to accumulate each Calendar Year (up to the applicable limit; see “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning on page 79) that you are enrolled in a CDHP option. If you do not continue coverage in a Retiree Medical Program E – CDHP option (for example, you enroll in a different Retiree Medical Program option or attain Medicare eligibility):

- If you have the Credit Approach, you will lose any remaining balance in your Health Fund; or
- If you have the RMSA, your remaining Health Fund balance will be transferred to your RMSA after 120 days from the date of your disenrollment from a CDHP option.

**In-Network Benefits**

In-Network benefits are provided by a group of doctors, Hospitals and other health care providers who participate in Cigna’s network. In-Network benefits typically have lower out-of-pocket costs than Out-of-Network benefits. The CDHP 80 pays 100% for eligible In-Network Preventive Care services, which are not subject to the annual Deductible. For most other In-Network care and services, your Participating Provider provides the services at a Negotiated Rate—the CDHP 80 pays 80%, and you pay 20% of the cost for Covered Services after you have met the annual Deductible. (See “Covered Services” beginning on page 85 for more information.)

You do not have to choose a Primary Care Physician (PCP) under the CDHP 80. You may visit any doctor within the network for routine or specialized care without a referral. Although the CDHP 80 does not require a PCP designation, you may still wish to choose a PCP. Establishing a relationship with a physician who knows you, your medical history and your current needs may help to ensure you
receive the most effective care. (See “Your Health Care Providers” in the section that follows for more information.)

**Your Health Care Providers**

When you enroll in the CDHP 80, you will receive an identification card. You may seek care from any provider in Cigna's network and services will be covered at the In-Network benefits level. Referrals to Specialists are not required. As long as you seek care from a Participating Provider, benefits will be paid at the In-Network benefits level. For any hospitalization, for certain Mental Health and Substance Use Disorder treatment and for certain surgical procedures, Precertification is required. You or your provider is responsible for having the care precertified by Cigna. (See “Precertification Rules” beginning on page 100 for more information.)

**Please note:** You will not be allowed to change your Retiree Medical Program option mid-year if a Participating Provider leaves the network.

**Where to Find Provider Information**

Provider directories under each health care carrier are available separately from this SPD booklet. If you need provider information, you may call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

Or, visit the Prudential Benefits Center website at [www.prubenefitscenter.com](http://www.prubenefitscenter.com) to find Participating Providers. You may also call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, and you will be assisted in obtaining provider information at no cost to you.

**Your Annual Deductible**

When you receive In-Network care or services (other than In-Network Preventive Care), you must meet an individual or family annual Deductible before the CDHP 80 will pay benefits.

The annual Deductible is:

- $1,500 per individual; and
- $3,000 per family.

The Health Fund helps you satisfy the annual Deductible.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the CDHP 80 will pay any Covered Expenses at the In-Network benefits level for the rest of that Calendar Year.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $1,400 Eligible Expense, then your child incurs a $550 Eligible Expense, and then your Spouse incurs a $1,900 Eligible Expense. The Eligible Expenses of all family members add up to $3,850. As a result, your $3,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $1,900 expense, the first $1,050 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

The annual Deductible Cross- Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

**Please note:** Prescription Drug charges do not apply toward the annual Deductible under the CDHP 80. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.
**Coinsurance**
Once you have met your annual Deductible, you and the CDHP 80 share in the cost of medical care and services through Coinsurance. The CDHP 80 pays 80% and you pay 20% of the Negotiated Rate for most In-Network Covered Services.

**Annual Out-of-Pocket Maximum**
The CDHP 80 Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maximums Cross-Apply. For example, if you incur $700 toward your In-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the Out-of-Network Annual Out-of-Pocket Maximum, and vice versa.

**Please note:** Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under the CDHP 80. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

**Individual Annual Out-of-Pocket Maximum**
The individual Annual Out-of-Pocket Maximum for In-Network services under the CDHP 80 is $4,000 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your In-Network out-of-pocket expenses reach the individual maximum, the CDHP 80 will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you.

**Please note:** There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under "Prescription Drug Benefits" beginning on page 99 after the individual Annual Out-of-Pocket Maximum is met.

**Family Annual Out-of-Pocket Maximum**
The family Annual Out-of-Pocket Maximum for In-Network services under the CDHP 80 is $8,000 per Calendar Year. The family maximum will be met when any combination of eligible In-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your In-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the CDHP 80 will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

**Please note:** There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under "Prescription Drug Benefits" beginning on page 99 after the family Annual Out-of-Pocket Maximum is met.

**Maximum Lifetime Benefit for Infertility Treatment**
There is an In-Network Maximum Lifetime Benefit of $20,000 for infertility treatment and a $10,000 Out-of-Network Maximum Lifetime Benefit for infertility treatment that Cross- Applies with the In-Network maximum.

For example, suppose you elect to receive infertility treatment Out-of-Network and the CDHP 80 pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the CDHP 80 will pay up to an additional:

- $2,000 for Out-of-Network treatment for a total of $10,000, the Out-of-Network Maximum Lifetime Benefit; or
- $12,000 for In-Network treatment which, when Cross-Applied with the $8,000 paid Out-of-Network, meets the $20,000 In-Network Maximum Lifetime Benefit.

So, while In-Network treatment will be covered up to the $20,000 Maximum Lifetime Benefit, up to $10,000 of that maximum may Cross-Apply (and reduce that maximum) with treatment received Out-of-Network.

Prescription Drug expenses for infertility treatment are covered under the Retiree Prescription Drug Program administered by Express Scripts and have a $6,000 lifetime maximum that does not count toward the CDHP 80’s infertility treatment Maximum Lifetime Benefit.

Covered Services
The CDHP 80 covers a wide variety of services as long as the services are Medically Necessary. The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

In-Network care and services include, but are not limited to:

**Preventive Care**
You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Preventive Care services are covered at 100%. In-Network Preventive Care services do not draw down your Health Fund. The annual Deductible does not apply to In-Network Preventive Care services. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations (including travel immunizations);
- Colonoscopies (including related services):
  - **Please note:** Prudential covers all In-Network colonoscopies and the ancillary services (for example, anesthesia, consultation) at 100%, regardless of whether the screening is preventive or diagnostic. If the ancillary services are not paid at 100%, usually due to billing timing issues, contact Cigna member services at 1-888-502-4462 and they will reprocess the claim accordingly;
- Adult routine physicals:
  - X-ray and lab services are covered at 100% when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;
- Well-woman care:
  - Anemia screening on a routine basis for pregnant women;
  - Bacteriuria urinary tract or other infection screening for pregnant women;
  - For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
— Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;

— Breast cancer mammography screenings every one to two years for women over age 40;

— Breast cancer chemoprevention counseling for women at higher risk;

— Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;

— Cervical cancer screening (Pap-tests) for sexually active women;

— Chlamydia infection screening for younger women and other women at higher risk;

— Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;

— Domestic and interpersonal violence screening and counseling for all women;

— Folic acid supplements for women who may become pregnant;

— Gestational diabetes screening;
  – For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  – Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;

— Gonorrhea screening for all women at higher risk;

— Hepatitis B screening for pregnant women at their first prenatal visit;

— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;

— Human Papillomavirus (HPV) DNA testing;

— Osteoporosis screening for women over age 60 depending on risk factors;

— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

— Sexually transmitted infection (STI) counseling for sexually active women;

— Syphilis screening for all pregnant women or other women at increased risk;

— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and

— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 100%, when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.
**Office Visits**

Office Visits are covered at 80% after you meet the annual Deductible unless otherwise noted below and include:

- Non-preventive x-ray and lab services;
- Office Visits (PCP and Specialists) for purposes other than Preventive Care;
- Maternity care:
  - Some prenatal services are covered at 100%. Please see the “Preventive Care” section beginning on page 85 for more details; and
  - Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
- Physical, occupational and speech therapy Office Visits (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - Please note: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Chiropractic care (up to 60 days per Calendar Year; the In-Network and Out-of-Network day maximums Cross-Apply); and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**

Hospital services are covered at 80% after you meet the annual Deductible and include:

- Surgery (Inpatient and Outpatient);
- Semi-private room and board at the Hospital;
- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);
- Pre-admission testing;
- Outpatient facility and supplies;
- Physical, occupational and speech therapy (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - Please note: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Ambulance services if Medically Necessary; and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**

Other services are covered at 80% after you meet the annual Deductible and include:

- X-rays or lab tests billed by a facility other than the prescribing doctor’s office;
- Delivery care and service at a Hospital or birthing center;
• Skilled nursing facility (up to 100 days per Calendar Year In-Network; the maximum Cross- Applies In-Network and Out-of-Network);

• Home Health Care (In-Network days count toward the Out-of-Network day maximum):
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and
  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:
  — Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;
  — Home health aid services;
  — Physical, occupational or speech therapy by a qualified therapist;
  — Dietary counseling;
  — Medical social services;
  — Medical supplies, drugs and medicines prescribed by a physician;
  — Lab services (provided by or for a Home Health Care agency); and
  — Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:
  — Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;
  — Services that do not require the technical skills of a medical, Mental Health or dental professional;
  — Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;
  — Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
  — Transportation services;
  — Services and supplies not Medically Necessary; and
  — Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.
If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

- Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

- Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $20,000 In-Network lifetime maximum, which Cross- Applies In-Network and Out-of-Network):
  
  — Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” beginning on page 99 for more information;

  — Infertility procedures are covered if:
    
    - A female member is unable to conceive or produce conception after:
      
      - One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;
      
      - Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or
      
      - At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);
    
    - The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, a network infertility specialist and the physician who diagnosed the member as infertile;
    
    - The procedures are done while not confined in a Hospital or any other facility as an Inpatient;
    
    - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
    
    - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;
    
    - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and
    
    - The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

- Durable medical equipment (for example, crutches, wheelchairs, braces);

- Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the CDHP 80 or for surgical removal of a tumor);

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and
• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:
  — Preventive counseling visits (maximum of eight visits per 12 months);
  — Treatment visits; and
  — Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:
• Charges for court-ordered services, including those required as a condition of parole or release;
• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;
• Macromastia or gynecomastia surgeries;
• Abdominoplasty;
• Panniculectomy;
• Redundant skin surgery;
• Removal of skin tags;
• Craniosacral/cranial therapy;
• Prolotherapy;
• Transportation services;
• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);
• Removal of an implant that alters the appearance of the body (such as breast or chin implants);
• Orthopedic footwear;
• Footwear to accommodate a diabetic condition;
• Surgical treatment of varicose veins;
• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;
• Home uterine activity monitoring;
• Residential Treatment Centers; and
• Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).
For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**

There are no claim forms required for In-Network services.

**Out-of-Network Benefits**

The CDHP 80 allows you to visit Out-of-Network providers and still receive benefits. When you visit an Out-of-Network provider, you:

- Meet an individual or family annual Deductible before the CDHP 80 starts to pay benefits; and
- Generally, pay the cost of care and services at the time you receive them. You are responsible for submitting a claim form to receive reimbursement for a percentage of Covered Expenses.

**Your Annual Deductible**

When you receive care Out-of-Network, you must meet an individual or family annual Deductible before the Program will pay benefits.

The annual Deductible is:

- $1,500 per individual; and
- $3,000 per family.

The Health Fund helps you satisfy the annual Deductible.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the CDHP 80 will pay any Covered Expenses at the Out-of-Network benefits level for the rest of that Calendar Year, up to Reasonable and Customary (R&C) limits. (See “Reasonable and Customary Fees” on page 92 for more information.) Any Out-of-Network charges above the R&C limits cannot be applied to the annual Deductible.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $1,400 Eligible Expense, then your child incurs a $550 Eligible Expense, and then your Spouse incurs a $1,900 Eligible Expense. The Eligible Expenses of all family members add up to $3,850. As a result, your $3,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $1,900 expense, the first $1,050 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

The annual Deductible Cross- Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

Please note: Prescription Drug charges do not apply toward the annual Deductible under the CDHP 80. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.

**Coinsurance**

Once you have met your annual Deductible, you and the CDHP 80 share in the cost of medical care and services through Coinsurance. The CDHP 80 pays 60% and you pay 40% of the R&C Fee for most Out-of-Network Covered Services. (See “Reasonable and Customary Fees” on page 92 for more information.)
Reasonable and Customary Fees

Reasonable and Customary (R&C) Fees are estimates of the typical charges for similar medical care and services within a specific geographic area. Under the CDHP 80, the R&C Fee is the amount that the CDHP 80 will consider for payment of an Out-of-Network Medically Necessary expense.

If your provider charges more than the R&C Fee, the actual amount above R&C Fees cannot be applied toward your annual Deductible. In addition, the Out-of-Network portion of the CDHP 80’s Coinsurance will cover 60% of the R&C Fee only; you will be responsible for your share of the Coinsurance, plus any amount in excess of the R&C Fees.

**Please note:** If you receive care and services In-Network, the fees charged by Participating Providers generally will not exceed the R&C Fee.

For example, suppose your provider charges $1,000 for a surgical expense, and the R&C Fee is $900. Assuming you have met your annual Deductible, your Out-of-Network benefits will pay 60% of the $900 R&C Fee, or $540. You will pay the remaining 40% of the $900 R&C Fee, or $360, plus the $100 difference between the R&C Fee and the actual charge. Your total out-of-pocket expense will be $460.

Annual Out-of-Pocket Maximum

The CDHP 80 Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maximums Cross-Apply In-Network and Out-of-Network. For example, if you incur $700 toward your Out-of-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the In-Network Annual Out-of-Pocket Maximum, and vice versa.

**Please note:** Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under the CDHP 80. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

Individual Annual Out-of-Pocket Maximum

The individual Annual Out-of-Pocket Maximum for Out-of-Network services under the CDHP 80 is $8,000 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once an individual’s Out-of-Network out-of-pocket expenses reach the individual maximum, the CDHP 80 will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses incurred by that individual for the rest of the Calendar Year. All other individuals will still be responsible for a portion of their Eligible Expenses.

**Please note:** There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 99 after the individual Annual Out-of-Pocket Maximum is met.

Family Annual Out-of-Pocket Maximum

The family Annual Out-of-Pocket Maximum for Out-of-Network services under the CDHP 80 is $16,000 per Calendar Year. The family maximum will be met when any combination of eligible Out-of-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your Out-of-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the CDHP 80 will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.
Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 99 after the family Annual Out-of-Pocket Maximum is met.

Maximum Lifetime Benefit for Infertility Treatment
There is an Out-of-Network Maximum Lifetime Benefit of $10,000 for infertility treatment that Cross- Applies with the $20,000 In-Network Maximum.

For example, suppose you elect to receive infertility treatment In-Network and the CDHP 80 pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the Program will pay up to an additional:

- $12,000 for In-Network treatment for a total of $20,000, the In-Network Maximum Lifetime Benefit; or
- $2,000 for Out-of-Network treatment which, when Cross-Applied with the $8,000 paid In-Network, meets the $10,000 Out-of-Network Maximum Lifetime Benefit.

So, while Out-of-Network treatment will be covered up to the $10,000 Maximum Lifetime Benefit, that maximum may Cross-Apply (and reduce that maximum) with treatment received In-Network.

Prescription Drug expenses for infertility treatment are covered under the Retiree Prescription Drug Program administered by Express Scripts and have a $6,000 lifetime maximum that does not apply toward the CDHP 80’s infertility treatment Maximum Lifetime Benefit. (See “Prescription Drug Benefits” beginning on page 99 for more information.)

Covered Services
The CDHP 80 covers a wide variety of services as long as the services are Medically Necessary. After you meet the annual Deductible, Out-of-Network care and services are covered at 60% of the R&C Fee. The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

Out-of-Network care and services include, but are not limited to:

Preventive Care
You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at www.cigna.com/prudential to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Out-of-Network Preventive Care services are covered at 60% of R&C Fees, after you meet the annual Deductible. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations (including travel immunizations);
- Colonoscopies (including related services);
- Adult routine physicals:
  - X-ray and lab services are covered at 60% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;
Well-woman care:

- Anemia screening on a routine basis for pregnant women;
- Bacteriuria urinary tract or other infection screening for pregnant women;
- For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
- Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;
- Breast cancer mammography screenings every one to two years for women over age 40;
- Breast cancer chemoprevention counseling for women at higher risk;
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
- Cervical cancer screening (Pap-tests) for sexually active women;
- Chlamydia infection screening for younger women and other women at higher risk;
- Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;
- Domestic and interpersonal violence screening and counseling for all women;
- Folic acid supplements for women who may become pregnant;
- Gestational diabetes screening;
  - For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  - Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;
- Gonorrhea screening for all women at higher risk;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
- Human Papillomavirus (HPV) DNA testing;
- Osteoporosis screening for women over age 60 depending on risk factors;
- Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;
- Sexually transmitted infection (STI) counseling for sexually active women;
- Syphilis screening for all pregnant women or other women at increased risk;
- Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and
- Well-woman visits to obtain recommended preventive services.
X-ray and lab services, such as Pap-tests and mammograms, are covered at 60% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.

**Office Visits**
- Non-preventive x-ray and lab services;
- Office Visits (PCP and Specialists) for purposes other than Preventive Care;
- Maternity care:
  - Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
- Physical, occupational and speech therapy Office Visits (up to 90 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum; this maximum is combined for all therapies):
  - Includes cognitive therapy and cardiac and pulmonary rehabilitation; and
  - Please note: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Chiropractic care (up to 60 days per Calendar Year; the day maximum Cross-Applies In-Network and Out-of-Network); and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**
- Surgery (Inpatient and Outpatient);
- Semi-private room and board at the Hospital;
- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);
- Pre-admission testing;
- Outpatient facility and supplies;
- Physical, occupational and speech therapy in a Hospital setting (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - Please note: Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Ambulance services if Medically Necessary; and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**
- Delivery care and service at a Hospital or birthing center;
- Skilled nursing facility (up to 60 days per Calendar Year Out-of-Network; the maximum Cross-Applies In-Network and Out-of-Network);

- Home Health Care (up to 100 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum):

  — The program covers certain services provided in a person's home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and

  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:

— Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

— Home health aid services;

— Physical, occupational or speech therapy by a qualified therapist;

— Dietary counseling;

— Medical social services;

— Medical supplies, drugs and medicines prescribed by a physician;

— Lab services (provided by or for a Home Health Care agency); and

— Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

— Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;

— Services that do not require the technical skills of a medical, Mental Health or dental professional;

— Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;

— Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;

— Transportation services;

— Services and supplies not Medically Necessary; and

— Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.
If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

- Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

- Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $10,000 Out-of-Network lifetime maximum, which Cross-Applies In-Network and Out-of-Network):
  - Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum or the Health Fund and are not covered Out-of-Network. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” beginning on page 99 for more information;
  - Infertility procedures are covered if:
    - A female member is unable to conceive or produce conception after:
      - One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;
      - Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or
      - At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);
    - The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, an infertility specialist and the physician who diagnosed the member as infertile;
    - The procedures are done while not confined in a Hospital or any other facility as an Inpatient;
    - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
    - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;
    - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and
    - The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

- Durable medical equipment (for example, crutches, wheelchairs, braces);

- Office Visits, Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the CDHP 80 or for surgical removal of tumors);

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and
• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:

— Preventive counseling visits (maximum of eight visits per 12 months);
— Treatment visits; and
— Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;
• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;
• Abdominoplasty;
• Panniculectomy;
• Redundant skin surgery;
• Removal of skin tags;
• Craniosacral/cranial therapy;
• Prolotherapy;
• Transportation services;
• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);
• Removal of an implant that alters the appearance of the body (such as breast or chin implants);
• Orthopedic footwear;
• Footwear to accommodate a diabetic condition;
• Surgical treatment of varicose veins;
• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;
• Home uterine activity monitoring;
• Residential Treatment Centers; and
• Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).
For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**

You must file a claim form for all Out-of-Network care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses. You will receive your claim reimbursement following the receipt and approval of your completed form. Claim forms are available on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)), by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

If your claim is denied, you have the right to appeal the decision. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.) You can also contact your health care carrier for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet the deadline, your claim will be denied.

**In Case of Emergency**

If you have a medical Emergency, defined as an illness or injury that could cause serious bodily harm if not treated immediately, you should go to the nearest Hospital emergency room or urgent care facility. You do not have to contact Cigna first to get Emergency care. Once you have the care you need, you should contact your personal physician to arrange for follow-up care.

If you are admitted to the Hospital, benefits are paid at 80% after you meet the annual Deductible as long as you call Cigna member services at 1-888-502-4462 within 48 hours of admission to the Hospital. (See “Precertification Rules” beginning on page 100 for more information.)

<table>
<thead>
<tr>
<th>Emergency Care Benefits At-A-Glance</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>Program pays 80% after annual Deductible is met</td>
<td>Program pays 80% after annual Deductible is met</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>Program pays 80% of Covered Charges after annual Deductible is met</td>
<td>Program pays 80% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for a true Emergency)</td>
<td>Program pays 80% of Covered Charges after annual Deductible is met</td>
<td>Program pays 80% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for routine or non-Emergency care)</td>
<td>Not covered*</td>
<td>Not covered*</td>
</tr>
</tbody>
</table>

*Ground ambulance support is covered if Medically Necessary, such as for transporting a patient from one Hospital to another. Contact Cigna for details.*

**Prescription Drug Benefits**

If you enroll in Retiree Medical Program E – CDHP 80, you will be enrolled automatically in the Retiree Prescription Drug Program administered by Express Scripts. You must purchase Prescription Drugs through the network of participating retail pharmacies or use the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar
Retiree Medical Program (Post-2000)—Page 100

minimums and maximums as the table beginning below illustrates. Prescription Drug expenses will not draw down your Health Fund.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retiree Prescription Drug Program Administered by Express Scripts¹,²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
</tr>
<tr>
<td></td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum³ and a $20.00 maximum</td>
</tr>
<tr>
<td></td>
<td>You pay 25% Coinsurance, subject to a $25.00 minimum⁴ and a $45.00 maximum</td>
</tr>
<tr>
<td></td>
<td>You pay 40% Coinsurance, subject to a $40.00 minimum⁵ and a $100.00 maximum</td>
</tr>
<tr>
<td></td>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
</tr>
<tr>
<td></td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
<tr>
<td></td>
<td>You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
</tr>
<tr>
<td></td>
<td>You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

¹ Prescription Drug expenses do not apply to the CDHP 80’s annual Deductible or the Annual Out-of-Pocket Maximum, and will not draw down your Health Fund.

² The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

³ At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

Other Important Features

<table>
<thead>
<tr>
<th>Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility Drugs (Oral and Injectables)</td>
</tr>
</tbody>
</table>

For more information about the Retiree Prescription Drug Program administered by Express Scripts, see “The Retiree Prescription Drug Program” beginning on page 31.

Precertification Rules

Precertification is an important tool in managing the quality and expense of Inpatient Hospital and facility admissions and certain Outpatient procedures and tests. You or your Participating Provider must call the toll-free number listed on your identification card to precertify Hospital admissions and certain Outpatient procedures and tests, as required by the CDHP 80 (see also “In Case of Emergency” on page 99 for more information). Failure to do so may affect your benefits. In an Emergency, seek care immediately then call your physician within 48 hours for further assistance and directions on follow-up care.

Precertification Rules At-A-Glance

<table>
<thead>
<tr>
<th>Retiree Medical Program E – CDHP 80</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
</tr>
<tr>
<td>Who should call</td>
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<tr>
<td>Where to call</td>
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Table continues on page 101
# Precertification Rules At-A-Glance
## Retiree Medical Program E – CDHP 80

<table>
<thead>
<tr>
<th>When to call</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) or Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) or Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
</tr>
<tr>
<td>If you call to precertify, and care is determined not Medically Necessary</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
<tr>
<td>If you do not call to precertify, but care is Medically Necessary</td>
<td>20% reduction in Eligible Expenses</td>
<td>20% reduction in Eligible Expenses</td>
</tr>
<tr>
<td>If you do not call to precertify, and care is not Medically Necessary</td>
<td>No coverage</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

## CDHP 80 Precertification

### For In-Network Care

You or your Participating Provider must contact Cigna patient management to request Precertification of your care.

### For Out-of-Network Care

For Out-of-Network care, you must call Cigna member services at 1-888-502-4462 to precertify care. When you call, you will speak with an experienced consultant who will determine the medical necessity of your admission and length of stay, and can advise you of alternative options that may be appropriate.

**If you do not call to precertify, the Eligible Expenses will be reduced by 20%.** If your admission, length of stay, surgical procedure or test is not considered Medically Necessary, no benefits will be paid.

The following Outpatient procedures and services require Precertification under the CDHP 80:

- All sinus surgery;
- Electroconvulsive therapy;
- Hysterectomy;
- Lumbar myelography;
- MRI – brain;
- MRI – lumbar;
- MRI – musculoskeletal;
• MRI – thoracic;
• Pelvic laparoscopy;
• PET scan;
• Psychological/neuropsychological testing of more than six hours;
• Outpatient detoxification involving methadone or suboxone;
• Intensive or structured Outpatient programs; and
• Biofeedback/neurofeedback.

This list is not all-inclusive and is subject to change. You should call Cigna member services at 1-888-502-4462 to determine whether your procedure requires Precertification.

In-Network Benefits for Special Situations

The CDHP 80 has provisions for special health care situations to ensure that you can get In-Network benefits whenever possible.

Medical Care While Traveling

Emergency Care

In an Emergency situation—whether you are traveling within or outside of your network area—you or your family should call 911 or seek treatment at the nearest Emergency facility or urgent care facility. If you are enrolled in the CDHP 80, you, your family or your physician should contact Cigna member services at 1-888-502-4462 within 48 hours of receiving Emergency care.

Non-Emergency Care

If medical care is necessary, but not an Emergency and you are enrolled in the CDHP 80, you should contact Cigna member services to find out if there is an affiliated network provider in the area. If so, Cigna can refer you to Participating Providers to ensure that you receive In-Network benefits. If not, you may see a non-Participating Provider. However, services will be reimbursed at the Out-of-Network level of benefits.

If you have a chronic condition, contact your personal physician before traveling to discuss any care requirements while you are away from home.

Medical Care for Students Outside the Network Service Area

If you are enrolled in the CDHP 80, you should contact Cigna member services to determine if there is a network in the area where your child attends school. If a local network is available, your child may use any provider in that network. Your child will receive the full range of In-Network benefits. If your child is not in a network area, follow the rules described under “Medical Care While Traveling” above.

Centers of Excellence Program

The CDHP 80 includes a “Centers of Excellence” Program, which provides access to medical facilities and staff who are experienced in specialty procedures such as organ and tissue transplants, cardiac bypass surgery, angioplasty and brain/spinal cord injuries. The CDHP 80 pays for Medically Necessary services and supplies involved with these procedures at the same benefit level as other services.

Cigna LIFESOURCE Organ Transplant Network

Cigna LIFESOURCE Organ Transplant Network is a network of nationally recognized medical centers that can provide the most appropriate care for members requiring organ or tissue transplants (including heart, heart/lung, lung, liver, kidney/pancreas and allogeneic bone marrow transplants). The Cigna LIFESOURCE Organ Transplant Network for Kids is also available to care for the special needs of children and their families. The CDHP 80 covers care and services In-Network at the 80%
Coinsurance amount after the annual Deductible and Out-of-Network at the 60% Coinsurance amount after the annual Deductible.

Transportation and lodging benefits are covered for the patient and a companion when using a Cigna LIFESOURCE facility. Travel expenses are covered up to a maximum of $10,000 per transplant, In-Network only.

**Cigna Healthy Rewards**

Through Cigna’s Healthy Rewards program, Cigna offers personalized services, online features and support to participants, including offering discounts on a variety of products and services. Access to Healthy Rewards is available regardless of which Cigna Retiree Medical Program option you enroll in. You can get more information regarding Healthy Rewards through the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) or by calling Cigna member services at 1-888-502-4462.
Retiree Medical Program E – CDHP 90

Retiree Medical Program E – Consumer Directed Health Program 90 (CDHP 90) provides non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents with a full range of health care services. Under the CDHP 90, you may choose health care services from Participating Providers—doctors, Hospitals and health care facilities that have agreed to provide Covered Services at reduced or Negotiated Fees—or you may go Out-of-Network to any health care provider you choose. When you use an Out-of-Network provider, you generally pay a higher cost for services than when you use a Participating Provider. You must satisfy an annual Deductible before the CDHP 90 will pay for most In-Network and Out-of-Network health care expenses. The CDHP 90 includes a Health Fund for you to use in paying for current health care expenses.

The CDHP 90 is administered by Cigna HealthCare (Cigna).

If you have questions regarding your benefits, please contact Cigna member services or visit the Cigna custom website for Prudential:

- Cigna member services:
  Telephone: 1-888-502-4462
  Website: www.cigna.com/prudential

The CDHP 90 is available to all non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents, regardless of where you live, except to those who reside in Hawaii, where the CDHP 90 is not available. Access to Cigna providers varies by location and may be limited in some areas. You should check Cigna’s Participating Providers to ensure you have adequate access to providers before enrolling in the CDHP 90 by going to the Cigna custom website for Prudential or by calling Cigna member services (contact information is listed above).

You can also visit the Prudential Benefits Center website at www.prubenefitscenter.com to find Participating Providers; or call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, to find out which programs are available to you.

How the Program Works

<table>
<thead>
<tr>
<th>Retiree Medical Program E – CDHP 90 ¹ At-A-Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
</tr>
<tr>
<td>Annual Deductible ²</td>
</tr>
<tr>
<td>Annual Deductible applies to both In-Network and Out-of-Network care</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum ² (includes annual Deductible)</td>
</tr>
<tr>
<td>$5,000 per individual, $10,000 per family</td>
</tr>
<tr>
<td>Please note that the Health Fund helps to offset a portion of your Annual Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>Annual Health Fund Allocation (helps satisfy the annual Deductible)</td>
</tr>
<tr>
<td>Annual Health Fund Limit</td>
</tr>
<tr>
<td>Preventive Care ³</td>
</tr>
<tr>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
</tr>
</tbody>
</table>

Table and footnotes continue on page 105
Retiree Medical Program E – CDHP 901 At-A-Glance

<table>
<thead>
<tr>
<th>Service</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care and Specialty Care Office Visits</td>
<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Hospital Stays</td>
<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>Program pays 90% after annual Deductible is met</td>
<td>Program pays 70% of R&amp;C Fees after annual Deductible is met</td>
</tr>
</tbody>
</table>

1 The CDHP 90 is not available in Hawaii.

2 Prescription Drug charges do not apply toward the annual Deductible or the Annual Out-of-Pocket Maximum under the CDHP 90. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible or the Annual Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.

3 Preventive Care benefits are subject to applicable age and frequency limits. Please contact Cigna for details.

Prescription Drugs

Retiree Prescription Drug Program Administered by Express Scripts1,2

<table>
<thead>
<tr>
<th>Service</th>
<th>Generic</th>
<th>Brand-Name Preferred</th>
<th>Brand-Name Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum(^3) and a $20.00 maximum</td>
<td>You pay 25% Coinsurance, subject to a $25.00 minimum(^3) and a $45.00 maximum</td>
<td>You pay 40% Coinsurance, subject to a $40.00 minimum(^3) and a $100.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
<td>You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
<td>You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

1 Prescription Drug expenses do not apply to the CDHP 90’s annual Deductible or the Annual Out-of-Pocket Maximum, and will not draw down your Health Fund.

2 The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

3 At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

The CDHP 90 offers you the choice of receiving In-Network or Out-of-Network care. In general, when you receive care:

- **In-Network**, you visit doctors and health care facilities that participate in Cigna’s network of Participating Providers. You need to meet the annual Deductible before the CDHP 90 starts to pay a percentage, called Coinsurance, of your covered health care expenses. Each time you need care and services, your Participating Provider provides the services at a Negotiated Rate—after you have met
the annual Deductible, the CDHP 90 pays 90% and you pay 10%. You do not need to file claim forms for In-Network care or services. Eligible Preventive Care services are not subject to the annual Deductible and are covered at 100%. If your costs for In-Network care reach the CDHP 90's Annual Out-of-Pocket Maximum, the CDHP 90 will pay 100% of your Covered Expenses for the rest of the Calendar Year, though Prescription Drug charges still apply; and

- **Out-of-Network**, you can visit any doctor or health care facility. You are responsible for submitting a claim form for reimbursement. You need to meet an annual Deductible amount before the CDHP 90 starts to pay a percentage, called Coinsurance, of your covered health care expenses. The CDHP 90 pays 70% of Reasonable and Customary (R&C) Fees and you pay 30% plus any amount above R&C Fees. If your costs for Out-of-Network care reach the CDHP 90's Annual Out-of-Pocket Maximum, the CDHP 90 will pay 100% of your Covered Expenses (up to R&C Fees) for the rest of the Calendar Year, though Prescription Drug charges still apply.

The program includes a Health Fund, which will help you meet the annual Deductible. If you do not use all the money in your Health Fund during the Calendar Year, you may carry the remaining balance (up to the applicable limit; see “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning below) into the next Calendar Year to pay for future health care expenses under the CDHP 80 or the CDHP 90.

**The Health Fund**

The Health Fund is a recordkeeping account that is established for each CDHP 90 participant to help pay for current health care expenses.

Your covered medical expenses (for example, office visits, labs, x-rays, hospital charges) will be paid under the CDHP 90, and any eligible out-of-pocket expenses will be automatically paid out of the Health Fund as long as there is an available balance. Your explanation of benefits (EOB) will identify the covered expenses, the portion of those charges that were paid from the Health Fund, the portion for which you are responsible to satisfy the annual Deductible and then the portion paid by the CDHP 90 versus the portion that is your responsibility (Coinsurance).

**How the Health Fund Works**

The Health Fund will be credited each January 1. Participants with You Only coverage will receive a credit of $500 and participants who cover one or more Qualified Dependent(s) (You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage categories) will receive a credit of $1,000.

**If You Use All the Money in Your Health Fund During the Calendar Year**

If you use all the money in your Health Fund during the Calendar Year, you must satisfy the balance of the annual Deductible, after which services will be covered at 90% (In-Network) or 70% of R&C Fees (Out-of-Network) until you reach the CDHP 90's Annual Out-of-Pocket Maximum ($2,500 for individual coverage or $5,000 for family coverage for In-Network care; $5,000 for individual coverage or $10,000 for family coverage for Out-of-Network care). Once you reach the Annual Out-of-Pocket Maximum, Eligible Expenses are covered at 100%, subject to R&C Fees for Out-of-Network services, for the remainder of the Calendar Year. Your Health Fund will be credited again on the next January 1.

**If You Do Not Use All the Money in Your Health Fund During the Calendar Year**

If you do not use all the money in your Health Fund during the Calendar Year, you may carry the remaining balance into the next Calendar Year to pay for future medical expenses under a Retiree Medical Program E – CDHP option. This carry-over happens automatically. In addition to your carried-over balance, your Health Fund will be credited again on the next January 1.

There is a limit on the amount you can have in your Health Fund annually. The limit is $800 for individual coverage and $1,600 if you cover one or more Dependents. Each year, the amount exceeding this limit will be treated differently depending on whether you have the Credit Approach or the RMSA:

- If you have the Credit Approach, any excess above the limit will be forfeited; or
• If you have the RMSA, any excess above the limit will be transferred to your RMSA on or after April 30 of the new program year.

When you leave the Retiree Medical Program E – CDHP option (for example, by enrolling in a different Retiree Medical Program option or attaining Medicare eligibility):

• If you have the Credit Approach, you will lose any remaining balance in your Health Fund; or

• If you have the RMSA, your remaining Health Fund balance will be transferred to your RMSA after 120 days from the date of your disenrollment from the Retiree Medical Program E – CDHP option.

Please see “Prudential’s Financial Support for Retiree Health Care Coverage Costs” beginning on page 6 for more information about the Credit Approach and the RMSA.

For example, a CDHP 90 participant in the **Credit Approach** could experience the following Health Fund carry-over scenario:

<table>
<thead>
<tr>
<th>Health Fund Carry-Over Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If You…</strong></td>
</tr>
<tr>
<td>Enrolled in a Retiree Medical Program E – CDHP option in 2013</td>
</tr>
<tr>
<td>Health Fund balance at end of 2013</td>
</tr>
<tr>
<td>2014 Health Fund allocation from Prudential</td>
</tr>
<tr>
<td>2014 Health Fund beginning balance</td>
</tr>
<tr>
<td>As a result of the Health Fund limit, on January 1, 2014, you will have:</td>
</tr>
<tr>
<td>2014 Health Fund usage</td>
</tr>
<tr>
<td>Health Fund balance at end of 2014</td>
</tr>
<tr>
<td>2015 Health Fund allocation from Prudential</td>
</tr>
<tr>
<td>2015 Health Fund beginning balance</td>
</tr>
<tr>
<td>As a result of the Health Fund limit, on January 1, 2015, you will have:</td>
</tr>
<tr>
<td>2015 Health Fund usage</td>
</tr>
</tbody>
</table>

*This is only an example. Health Fund allocations from Prudential for future years are subject to change.*

A CDHP 90 participant in the **RMSA** could experience the following Health Fund carry-over scenario:

<table>
<thead>
<tr>
<th>Health Fund Carry-Over Feature</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If You…</strong></td>
</tr>
<tr>
<td>Enrolled in Retiree Medical Program E – CDHP in 2013</td>
</tr>
<tr>
<td>Health Fund balance at end of 2013</td>
</tr>
<tr>
<td>2014 Health Fund allocation from Prudential</td>
</tr>
<tr>
<td>Table and footnote continue on page 108</td>
</tr>
</tbody>
</table>
## Health Fund Carry-Over Feature

<table>
<thead>
<tr>
<th>If You…</th>
<th>Elect Individual Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014 Health Fund beginning balance</td>
<td>Total amount in your Health Fund is $1,250 ($750 carry-over from 2013 plus $500 Health Fund allocation for 2014)</td>
</tr>
</tbody>
</table>

As a result of the Health Fund limit, on January 1, 2014, you will have:

- $800 in your Health Fund; and
- $450 transferred to your RMSA on or after April 30 of the new program year due to the Health Fund limit ($1,250 balance minus the $800 limit)

| 2014 Health Fund usage | $400 |
| Health Fund balance at end of 2014 | $400 |
| 2015 Health Fund allocation from Prudential | $500* |

| 2015 Health Fund beginning balance | Total amount in your Health Fund is $900 ($400 carry-over from 2014 plus $500 Health Fund allocation for 2014) |

As a result of the Health Fund limit, on January 1, 2015, you will have:

- $800 in your Health Fund; and
- $100 transferred to your RMSA on or after April 30 of the new program year due to the Health Fund limit ($900 balance minus the $800 limit)

*This is only an example. Health Fund allocations from Prudential for future years are subject to change.*

### If You Enroll During the Calendar Year

If you become a new participant mid-year or you enrolled in the CDHP 90 mid-year due to a Qualified Change in Status, the initial amount credited to your Health Fund will be pro-rated based on your date of enrollment. You will receive the Health Fund allocation based on the quarter during which you join the CDHP 90. All dates within the quarter will be treated equally. During the first quarter, the initial amount credited to your Health Fund account is not reduced. Subsequent quarters are reduced as follows:

- Second quarter reduced by 25%;
- Third quarter reduced by 50%; and
- Fourth quarter reduced by 75%.

### If You Add or Remove a Dependent During the Calendar Year

If you are enrolled in the CDHP 90 with You Only coverage and experience a Qualified Change in Status mid-year in which you change from You Only coverage to You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, the amount credited to your Health Fund will change from the individual amount of $500 to the family amount of $1,000, but this increase will be pro-rated based on the date of your Qualified Change in Status. You will receive the increased Health Fund allocation based on the quarter in which your Qualified Change in Status was effective. All dates within the quarter will be treated equally. During the first quarter, the amount credited to your Health Fund account is not reduced. Subsequent quarters are reduced as follows:

- Second quarter reduced by 25%;
- Third quarter reduced by 50%; and
- Fourth quarter reduced by 75%.

If you are enrolled in the CDHP 90 with You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage and experience a Qualified Change in Status mid-year in which you change your You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage to You Only coverage,
the amount credited to your Health Fund will decrease from the family amount of $1,000 to the lesser of: (a) the individual Health Fund amount of $500; and (b) the balance of the Health Fund on the day prior to the Qualified Change in Status.

The following two examples provide clarification for how changing to You Only coverage mid-year affects the Health Fund:

1) You are enrolled in the CDHP 90 with You + Spouse/Qualified Adult coverage. You have a Health Fund balance of $1,000 at the beginning of the Calendar Year. You or your Spouse, or a combination of both you and your Spouse, incur medical claims totaling $250 in February. Your Health Fund will be used to pay the $250, at which point, you will have $750 remaining in your Health Fund. In April, you have a Qualified Change in Status due to divorce, and your coverage changes from You + Spouse/Qualified Adult coverage to You Only coverage. At that time, your Health Fund balance will reduce to $500, which will be available to you for the remainder of the Calendar Year; or

2) You are enrolled in the CDHP 90 with You + Spouse/Qualified Adult coverage. You have a Health Fund balance of $1,000 at the beginning of the Calendar Year. You or your Spouse, or a combination of both you and your Spouse, incur medical claims totaling $750 in February. Your Health Fund will be used to pay the $750, at which point, you will have $250 remaining in your Health Fund. In April, you have a Qualified Change in Status due to divorce, and your coverage changes from You + Spouse/Qualified Adult coverage to You Only coverage. At that time, you have a Health Fund balance of $250, which is already less than the $500 individual amount for the Health Fund, so the Health Fund balance available to you for the remainder of the Calendar Year is $250.

Any Health Fund amount that you may have carried forward from a prior Calendar Year that has not been used as of the date of the change in status, and that remains unused, would still be available to you as long as it does not exceed the applicable limits. If it exceeds the maximum amount you may have in the Health Fund and you elected the Credit Approach, the excess amount will be forfeited on or after April 30 of the new program year. If it exceeds the maximum amount you may have in the Health Fund and you elected the RMSA, the excess amount will be transferred to your RMSA on or after April 30 of the new program year. See “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning on page 106.

If Your CDHP Enrollment Ends During the Calendar Year
Your Health Fund balance will continue to accumulate each Calendar Year (up to the applicable limit; see “If You Do Not Use All the Money in Your Health Fund During the Calendar Year” beginning on page 106) that you are enrolled in a CDHP option. If you do not continue coverage in a Retiree Medical Program E – CDHP option (for example, you enroll in a different Retiree Medical Program option or attain Medicare eligibility):

- If you have the Credit Approach, you will lose any remaining balance in your Health Fund; or

- If you have the RMSA, your remaining Health Fund balance will be transferred to your RMSA after 120 days from the date of your disenrollment from a CDHP option.

In-Network Benefits
In-Network benefits are provided by a group of doctors, Hospitals and other health care providers who participate in Cigna’s network. In-Network benefits typically have lower out-of-pocket costs than Out-of-Network benefits. The CDHP 90 pays 100% for eligible In-Network Preventive Care services, which are not subject to the annual Deductible. For most other In-Network care and services, your Participating Provider provides the services at a Negotiated Rate—the CDHP 90 pays 90%, and you pay 10% of the cost for Covered Services after you have met the annual Deductible. (See “Covered Services” beginning on page 112 for more information.)

You do not have to choose a Primary Care Physician (PCP) under the CDHP 90. You may visit any doctor within the network for routine or specialized care without a referral. Although the CDHP 90 does not require a PCP designation, you may still wish to choose a PCP. Establishing a relationship with a physician who knows you, your medical history and your current needs may help to ensure you
receive the most effective care. (See “Your Health Care Providers” in the section that follows for more information.)

**Your Health Care Providers**

When you enroll in the CDHP 90, you will receive an identification card. You may seek care from any provider in Cigna's network and services will be covered at the In-Network benefits level. Referrals to Specialists are not required. As long as you seek care from a Participating Provider, benefits will be paid at the In-Network benefits level. For any hospitalization, for certain Mental Health and Substance Use Disorder treatment and for certain surgical procedures, Precertification is required. You or your provider is responsible for having the care precertified by Cigna. (See “Precertification Rules” beginning on page 127 for more information.)

*Please note:* You will not be allowed to change your Retiree Medical Program option mid-year if a Participating Provider leaves the network.

**Where to Find Provider Information**

Provider directories under each health care carrier are available separately from this SPD booklet. If you need provider information, you may call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

Or, visit the Prudential Benefits Center website at [www.prubenefitscenter.com](http://www.prubenefitscenter.com) to find Participating Providers. You may also call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, and you will be assisted in obtaining provider information at no cost to you.

**Your Annual Deductible**

When you receive In-Network care or services (other than In-Network Preventive Care), you must meet an individual or family annual Deductible before the CDHP 90 will pay benefits.

The annual Deductible is:

- $1,000 per individual; and
- $2,000 per family.

The Health Fund helps you satisfy the annual Deductible.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the CDHP 90 will pay any Covered Expenses at the In-Network benefits level for the rest of that Calendar Year.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $900 Eligible Expense, then your child incurs a $550 Eligible Expense, and then your Spouse incurs a $1,900 Eligible Expense. The Eligible Expenses of all family members add up to $3,350. As a result, your $2,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $1,900 expense, the first $550 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

The annual Deductible Cross-Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

*Please note:* Prescription Drug charges do not apply toward the annual Deductible under the CDHP 90. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.
Coinsurance
Once you have met your annual Deductible, you and the CDHP 90 share in the cost of medical care and services through Coinsurance. The CDHP 90 pays 90% and you pay 10% of the Negotiated Rate for most In-Network Covered Services.

Annual Out-of-Pocket Maximum
The CDHP 90 Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maxima Maxims Cross-Apply. For example, if you incur $700 toward your In-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the Out-of-Network Annual Out-of-Pocket Maximum, and vice versa.

Please note: Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under the CDHP 90. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

Individual Annual Out-of-Pocket Maximum
The individual Annual Out-of-Pocket Maximum for In-Network services under the CDHP 90 is $2,500 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your In-Network out-of-pocket expenses reach the individual maximum, the CDHP 90 will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you.

Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 126 after the individual Annual Out-of-Pocket Maximum is met.

Family Annual Out-of-Pocket Maximum
The family Annual Out-of-Pocket Maximum for In-Network services under the CDHP 90 is $5,000 per Calendar Year. The family maximum will be met when any combination of eligible In-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your In-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the CDHP 90 will pay 100% for any further eligible In-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 126 after the family Annual Out-of-Pocket Maximum is met.

Maximum Lifetime Benefit for Infertility Treatment
There is an In-Network Maximum Lifetime Benefit of $20,000 for infertility treatment and a $10,000 Out-of-Network Maximum Lifetime Benefit for infertility treatment that Cross-Apply with the In-Network maximum.

For example, suppose you elect to receive infertility treatment Out-of-Network and the CDHP 90 pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the CDHP 90 will pay up to an additional:

- $2,000 for Out-of-Network treatment for a total of $10,000, the Out-of-Network Maximum Lifetime Benefit; or
• $12,000 for In-Network treatment which, when Cross-Applied with the $8,000 paid Out-of-Network, meets the $20,000 In-Network Maximum Lifetime Benefit.

So, while In-Network treatment will be covered up to the $20,000 Maximum Lifetime Benefit, up to $10,000 of that maximum may Cross-Apply (and reduce that maximum) with treatment received Out-of-Network.

Prescription Drug expenses for infertility treatment are covered under the Retiree Prescription Drug Program administered by Express Scripts and have a $6,000 lifetime maximum that does not count toward the CDHP 90's infertility treatment Maximum Lifetime Benefit.

**Covered Services**

The CDHP 90 covers a wide variety of services as long as the services are Medically Necessary. The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

In-Network care and services include, but are not limited to:

**Preventive Care**

You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Preventive Care services are covered at 100%. In-Network Preventive Care services do not draw down your Health Fund. The annual Deductible does not apply to In-Network Preventive Care services. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

• Well-child care;

• Immunizations (including travel immunizations);

• Colonoscopies (including related services):
  
  — Please note: Prudential covers all In-Network colonoscopies and the ancillary services (for example, anesthesia, consultation) at 100%, regardless of whether the screening is preventive or diagnostic. If the ancillary services are not paid at 100%, usually due to billing timing issues, contact Cigna member services at 1-888-502-4462 and they will reprocess the claim accordingly;

• Adult routine physicals:
  
  — X-ray and lab services are covered at 100% when incurred as a result of a routine physical. This includes charges billed by a physician's office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  
  — Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;

• Well-woman care:
  
  — Anemia screening on a routine basis for pregnant women;
  
  — Bacteriuria urinary tract or other infection screening for pregnant women;
  
  — For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
— Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;

— Breast cancer mammography screenings every one to two years for women over age 40;

— Breast cancer chemoprevention counseling for women at higher risk;

— Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;

— Cervical cancer screening (Pap-tests) for sexually active women;

— Chlamydia infection screening for younger women and other women at higher risk;

— Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;

— Domestic and interpersonal violence screening and counseling for all women;

— Folic acid supplements for women who may become pregnant;

— Gestational diabetes screening;
  - For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  - Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;

— Gonorrhea screening for all women at higher risk;

— Hepatitis B screening for pregnant women at their first prenatal visit;

— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;

— Human Papillomavirus (HPV) DNA testing;

— Osteoporosis screening for women over age 60 depending on risk factors;

— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

— Sexually transmitted infection (STI) counseling for sexually active women;

— Syphilis screening for all pregnant women or other women at increased risk;

— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and

— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 100%, when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.
**Office Visits**

Office Visits are covered at 90% after you meet the annual Deductible unless otherwise noted below and include:

- Non-preventive x-ray and lab services;
- Office Visits (PCP and Specialists) for purposes other than Preventive Care;
- Maternity care:
  - Some prenatal services are covered at 100%. Please see the “Preventive Care” section beginning on page 112 for more details; and
  - Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
- Physical, occupational and speech therapy Office Visits (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Chiropractic care (up to 60 days per Calendar Year; the In-Network and Out-of-Network day maximums Cross-Apply); and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**

Hospital services are covered at 90% after you meet the annual Deductible and include:

- Surgery (Inpatient and Outpatient);
- Semi-private room and board at the Hospital;
- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);
- Pre-admission testing;
- Outpatient facility and supplies;
- Physical, occupational and speech therapy (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Ambulance services if Medically Necessary; and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**

Other services are covered at 90% after you meet the annual Deductible and include:

- X-rays or lab tests billed by a facility other than the prescribing doctor’s office;
- Delivery care and service at a Hospital or birthing center;
• Skilled nursing facility (up to 100 days per Calendar Year In-Network; the maximum Cross- Applies In-Network and Out-of-Network);

• Home Health Care (In-Network days count toward the Out-of-Network day maximum):
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and
  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:
  — Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;
  — Home health aid services;
  — Physical, occupational or speech therapy by a qualified therapist;
  — Dietary counseling;
  — Medical social services;
  — Medical supplies, drugs and medicines prescribed by a physician;
  — Lab services (provided by or for a Home Health Care agency); and
  — Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:
  — Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;
  — Services that do not require the technical skills of a medical, Mental Health or dental professional;
  — Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;
  — Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
  — Transportation services;
  — Services and supplies not Medically Necessary; and
  — Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.
If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

- Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

- Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $20,000 In-Network lifetime maximum, which Cross-Applies In-Network and Out-of-Network):
  
  — Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” beginning on page 126 for more information;

  — Infertility procedures are covered if:
    
    - A female member is unable to conceive or produce conception after:
      
      • One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;

      • Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or

      • At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);

    - The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, a network infertility specialist and the physician who diagnosed the member as infertile;

    - The procedures are done while not confined in a Hospital or any other facility as an Inpatient;

    - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;

    - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;

    - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and

    - The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

- Durable medical equipment (for example, crutches, wheelchairs, braces);

- Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the CDHP 90 or for surgical removal of a tumor);

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and
• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:
  — Preventive counseling visits (maximum of eight visits per 12 months);
  — Treatment visits; and
  — Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;

• Abdominoplasty;

• Panniculectomy;

• Redundant skin surgery;

• Removal of skin tags;

• Craniosacral/cranial therapy;

• Prolotherapy;

• Transportation services;

• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);

• Removal of an implant that alters the appearance of the body (such as breast or chin implants);

• Orthopedic footwear;

• Footwear to accommodate a diabetic condition;

• Surgical treatment of varicose veins;

• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;

• Home uterine activity monitoring;

• Residential Treatment Centers; and

• Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).
For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**
There are no claim forms required for In-Network services.

**Out-of-Network Benefits**
The CDHP 90 allows you to visit Out-of-Network providers and still receive benefits. When you visit an Out-of-Network provider, you:

- Meet an individual or family annual Deductible before the CDHP 90 starts to pay benefits; and

- Generally, pay the cost of care and services at the time you receive them. You are responsible for submitting a claim form to receive reimbursement for a percentage of Covered Expenses.

**Your Annual Deductible**
When you receive care Out-of-Network, you must meet an individual or family annual Deductible before the Program will pay benefits.

The annual Deductible is:

- $1,000 per individual; and

- $2,000 per family.

The Health Fund helps you satisfy the annual Deductible.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the CDHP 90 will pay any Covered Expenses at the Out-of-Network benefits level for the rest of that Calendar Year, up to Reasonable and Customary (R&C) limits. (See “Reasonable and Customary Fees” on page 119 for more information.) Any Out-of-Network charges above the R&C limits cannot be applied to the annual Deductible.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $900 Eligible Expense, then your child incurs a $550 Eligible Expense, and then your Spouse incurs a $1,900 Eligible Expense. The Eligible Expenses of all family members add up to $3,350. As a result, your $2,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $1,900 expense, the first $550 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the appropriate Coinsurance level, depending on whether the Eligible Expense was incurred In-Network or Out-of-Network.

The annual Deductible Cross- Applies to In-Network and Out-of-Network Eligible Expenses. Both your In-Network and Out-of-Network Eligible Expenses will count toward your annual Deductible.

**Please note:** Prescription Drug charges do not apply toward the annual Deductible under the CDHP 90. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.

**Coinsurance**
Once you have met your annual Deductible, you and the CDHP 90 share in the cost of medical care and services through Coinsurance. The CDHP 90 pays 70% and you pay 30% of the R&C Fee for most Out-of-Network Covered Services. (See “Reasonable and Customary Fees” on page 119 for more information.)
**Reasonable and Customary Fees**

Reasonable and Customary (R&C) Fees are estimates of the typical charges for similar medical care and services within a specific geographic area. Under the CDHP 90, the R&C Fee is the amount that the CDHP 90 will consider for payment of an Out-of-Network Medically Necessary expense.

If your provider charges more than the R&C Fee, the actual amount above R&C Fees cannot be applied toward your annual Deductible. In addition, the Out-of-Network portion of the CDHP 90’s Coinsurance will cover 70% of the R&C Fee only; you will be responsible for your share of the Coinsurance, plus any amount in excess of the R&C Fees.

**Please note:** If you receive care and services In-Network, the fees charged by Participating Providers generally will not exceed the R&C Fee.

For example, suppose your provider charges $1,000 for a surgical expense, and the R&C Fee is $900. Assuming you have met your annual Deductible, your Out-of-Network benefits will pay 70% of the $900 R&C Fee, or $630. You will pay the remaining 30% of the $900 R&C Fee, or $270, plus the $100 difference between the R&C Fee and the actual charge. Your total out-of-pocket expense will be $370.

**Annual Out-of-Pocket Maximum**

The CDHP 90 Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury. There is an Annual Out-of-Pocket Maximum that applies for In-Network charges and an Annual Out-of-Pocket Maximum that applies for Out-of-Network charges. These two Annual Out-of-Pocket Maximums Cross-Apply In-Network and Out-of-Network. For example, if you incur $700 toward your Out-of-Network Annual Out-of-Pocket Maximum, you will be deemed to have satisfied $700 toward the In-Network Annual Out-of-Pocket Maximum, and vice versa.

**Please note:** Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under the CDHP 90. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

**Individual Annual Out-of-Pocket Maximum**

The individual Annual Out-of-Pocket Maximum for Out-of-Network services under the CDHP 90 is $5,000 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once an individual’s Out-of-Network out-of-pocket expenses reach the individual maximum, the CDHP 90 will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses incurred by that individual for the rest of the Calendar Year. All other individuals will still be responsible for a portion of their Eligible Expenses.

**Please note:** There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 126 after the individual Annual Out-of-Pocket Maximum is met.

**Family Annual Out-of-Pocket Maximum**

The family Annual Out-of-Pocket Maximum for Out-of-Network services under the CDHP 90 is $10,000 per Calendar Year. The family maximum will be met when any combination of eligible Out-of-Network expenses incurred by you and your Covered Qualified Dependents reaches the out-of-pocket limit. The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once your Out-of-Network out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the CDHP 90 will pay 100% of the R&C Fee for any further eligible Out-of-Network expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.
Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 126 after the family Annual Out-of-Pocket Maximum is met.

Maximum Lifetime Benefit for Infertility Treatment

There is an Out-of-Network Maximum Lifetime Benefit of $10,000 for infertility treatment that Cross- Applies with the $20,000 In-Network Maximum.

For example, suppose you elect to receive infertility treatment In-Network and the CDHP 90 pays $8,000 toward the cost of your treatment. Then, if you receive additional infertility treatment, the Program will pay up to an additional:

- $12,000 for In-Network treatment for a total of $20,000, the In-Network Maximum Lifetime Benefit; or
- $2,000 for Out-of-Network treatment which, when Cross- Applied with the $8,000 paid In-Network, meets the $10,000 Out-of-Network Maximum Lifetime Benefit.

So, while Out-of-Network treatment will be covered up to the $10,000 Maximum Lifetime Benefit, that maximum may Cross-Apply (and reduce that maximum) with treatment received In-Network.

Prescription Drug expenses for infertility treatment are covered under the Retiree Prescription Drug Program administered by Express Scripts and have a $6,000 lifetime maximum that does not apply toward the CDHP 90’s infertility treatment Maximum Lifetime Benefit. (See “Prescription Drug Benefits” beginning on page 126 for more information.)

Covered Services

The CDHP 90 covers a wide variety of services as long as the services are Medically Necessary. After you meet the annual Deductible, Out-of-Network care and services are covered at 70% of the R&C Fee.

The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

Out-of-Network care and services include, but are not limited to:

**Preventive Care**

You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Out-of-Network Preventive Care services are covered at 70% of R&C Fees, after you meet the annual Deductible. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations (including travel immunizations);
- Colonoscopies (including related services);
- Adult routine physicals:
  - X-ray and lab services are covered at 70% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;
• Well-woman care:

— Anemia screening on a routine basis for pregnant women;

— Bacteriuria urinary tract or other infection screening for pregnant women;

— For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;

— Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;

— Breast cancer mammography screenings every one to two years for women over age 40;

— Breast cancer chemoprevention counseling for women at higher risk;

— Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;

— Cervical cancer screening (Pap-tests) for sexually active women;

— Chlamydia infection screening for younger women and other women at higher risk;

— Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;

— Domestic and interpersonal violence screening and counseling for all women;

— Folic acid supplements for women who may become pregnant;

— Gestational diabetes screening;

  — For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and

  — Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;

— Gonorrhea screening for all women at higher risk;

— Hepatitis B screening for pregnant women at their first prenatal visit;

— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;

— Human Papillomavirus (HPV) DNA testing;

— Osteoporosis screening for women over age 60 depending on risk factors;

— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

— Sexually transmitted infection (STI) counseling for sexually active women;

— Syphilis screening for all pregnant women or other women at increased risk;

— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and

— Well-woman visits to obtain recommended preventive services.
X-ray and lab services, such as Pap-tests and mammograms, are covered at 70% of R&C Fees after you meet the annual Deductible when incurred as a result of a routine physical. This includes charges billed by a physician’s office, an independent lab or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.

**Office Visits**
- Non-preventive x-ray and lab services;
- Office Visits (PCP and Specialists) for purposes other than Preventive Care;
- Maternity care:
  - Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
- Physical, occupational and speech therapy Office Visits (up to 90 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum; this maximum is combined for all therapies):
  - Includes cognitive therapy and cardiac and pulmonary rehabilitation; and
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Chiropractic care (up to 60 days per Calendar Year; the day maximum Cross-Applies In-Network and Out-of-Network); and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**
- Surgery (Inpatient and Outpatient);
- Semi-private room and board at the Hospital;
- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);
- Pre-admission testing;
- Outpatient facility and supplies;
- Physical, occupational and speech therapy in a Hospital setting (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Ambulance services if Medically Necessary; and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**
- Delivery care and service at a Hospital or birthing center;
Skilled nursing facility (up to 60 days per Calendar Year Out-of-Network; the maximum Cross-Applies In-Network and Out-of-Network);

Home Health Care (up to 100 days per Calendar Year; In-Network days count toward the Out-of-Network day maximum):

- The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and

- The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:

- Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

- Home health aid services;

- Physical, occupational or speech therapy by a qualified therapist;

- Dietary counseling;

- Medical social services;

- Medical supplies, drugs and medicines prescribed by a physician;

- Lab services (provided by or for a Home Health Care agency); and

- Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

- Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;

- Services that do not require the technical skills of a medical, Mental Health or dental professional;

- Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;

- Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;

- Transportation services;

- Services and supplies not Medically Necessary; and

- Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.
If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

- Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

- Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $10,000 Out-of-Network lifetime maximum, which Cross- Applies In-Network and Out-of-Network):
  - Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum or the Health Fund and are not covered Out-of-Network. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” beginning on page 126 for more information;
  - Infertility procedures are covered if:
    - A female member is unable to conceive or produce conception after:
      - One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;
      - Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or
      - At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);
    - The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, an infertility specialist and the physician who diagnosed the member as infertile;
    - The procedures are done while not confined in a Hospital or any other facility as an Inpatient;
    - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
    - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;
    - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and
    - The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

- Durable medical equipment (for example, crutches, wheelchairs, braces);

- Office Visits, Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the CDHP 90 or for surgical removal of tumors);

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and
• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:

— Preventive counseling visits (maximum of eight visits per 12 months);

— Treatment visits; and

— Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

For more information, check the Cigna schedule of benefits regarding gender reassignment surgery. A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;

• Abdominoplasty;

• Panniculectomy;

• Redundant skin surgery;

• Removal of skin tags;

• Craniosacral/cranial therapy;

• Prolotherapy;

• Transportation services;

• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);

• Removal of an implant that alters the appearance of the body (such as breast or chin implants);

• Orthopedic footwear;

• Footwear to accommodate a diabetic condition;

• Surgical treatment of varicose veins;

• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;

• Home uterine activity monitoring;

• Residential Treatment Centers; and

• Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).
For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**Filing Claims**

You must file a claim form for all Out-of-Network care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses. You will receive your claim reimbursement following the receipt and approval of your completed form. Claim forms are available on the Prudential Benefits Center website (at www.prubenefitscenter.com), by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at www.cigna.com/prudential).

If your claim is denied, you have the right to appeal the decision. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.) You can also contact your health care carrier for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet the deadline, your claim will be denied.

**In Case of Emergency**

If you have a medical Emergency, defined as an illness or injury that could cause serious bodily harm if not treated immediately, you should go to the nearest Hospital emergency room or urgent care facility. You do not have to contact Cigna first to get Emergency care. Once you have the care you need, you should contact your personal physician to arrange for follow-up care.

If you are admitted to the Hospital, benefits are paid at 90% after you meet the annual Deductible as long as you call Cigna member services at 1-888-502-4462 within 48 hours of admission to the Hospital. (See “Precertification Rules” beginning on page 127 for more information.)

<table>
<thead>
<tr>
<th>Emergency Care Benefits At-A-Glance</th>
<th>Retiree Medical Program E – CDHP 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Emergency room</td>
<td>Program pays 90% after annual Deductible is met</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>Program pays 90% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for a true Emergency)</td>
<td>Program pays 90% of Covered Charges after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for routine or non-Emergency care)</td>
<td>Not covered*</td>
</tr>
</tbody>
</table>

*Ground ambulance support is covered if Medically Necessary, such as for transporting a patient from one Hospital to another. Contact Cigna for details.*

**Prescription Drug Benefits**

If you enroll in Retiree Medical Program E – CDHP 90, you will be enrolled automatically in the Retiree Prescription Drug Program administered by Express Scripts. You must purchase Prescription Drugs through the network of participating retail pharmacies or use the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar
minimunm and maximums as the table beginning below illustrates. Prescription Drug expenses will not draw down your Health Fund.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retiree Prescription Drug Program Administered by Express Scripts¹,²</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum³ and a $20.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
<tr>
<td></td>
<td>Brand-Name Preferred</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $25.00 minimum³ and a $45.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
</tr>
<tr>
<td></td>
<td>Brand-Name Non-Preferred</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 40% Coinsurance, subject to a $40.00 minimum³ and a $100.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

¹ Prescription Drug expenses do not apply to the CDHP 90’s annual Deductible or the Annual Out-of-Pocket Maximum, and will not draw down your Health Fund.

² The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

³ At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

Other Important Features

<table>
<thead>
<tr>
<th>Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility Drugs (Oral and Injectables)</td>
</tr>
</tbody>
</table>

For more information about the Retiree Prescription Drug Program administered by Express Scripts, see “The Retiree Prescription Drug Program” beginning on page 31.

Precertification Rules

Precertification is an important tool in managing the quality and expense of Inpatient Hospital and facility admissions and certain Outpatient procedures and tests. You or your Participating Provider must call the toll-free number listed on your identification card to precertify Hospital admissions and certain Outpatient procedures and tests, as required by the CDHP 90 (see also “In Case of Emergency” beginning on page 126 for more information). Failure to do so may affect your benefits. In an Emergency, seek care immediately then call your physician within 48 hours for further assistance and directions on follow-up care.

Precertification Rules At-A-Glance

<table>
<thead>
<tr>
<th>Retiree Medical Program E – CDHP 90</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-Network</td>
</tr>
<tr>
<td>Who should call</td>
</tr>
<tr>
<td>Where to call</td>
</tr>
<tr>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Who should call</td>
</tr>
<tr>
<td>Where to call</td>
</tr>
</tbody>
</table>

Table continues on page 128
## Precertification Rules At-A-Glance

**Retiree Medical Program E – CDHP 90**

<table>
<thead>
<tr>
<th>When to call</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) or Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) or Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
</tr>
</tbody>
</table>

| If you call to precertify, and care is determined not Medically Necessary | No coverage | No coverage |
| If you do not call to precertify, but care is Medically Necessary | 20% reduction in Eligible Expenses | 20% reduction in Eligible Expenses |
| If you do not call to precertify, and care is not Medically Necessary | No coverage | No coverage |

### CDHP 90 Precertification

**For In-Network Care**

You or your Participating Provider must contact Cigna patient management to request Precertification of your care.

**For Out-of-Network Care**

For Out-of-Network care, you must call Cigna member services at 1-888-502-4462 to precertify care. When you call, you will speak with an experienced consultant who will determine the medical necessity of your admission and length of stay, and can advise you of alternative options that may be appropriate.

**If you do not call to precertify, the Eligible Expenses will be reduced by 20%**. If your admission, length of stay, surgical procedure or test is not considered Medically Necessary, no benefits will be paid.

The following Outpatient procedures and services require Precertification under the CDHP 90:

- All sinus surgery;
- Electroconvulsive therapy;
- Hysterectomy;
- Lumbar myelography;
- MRI – brain;
- MRI – lumbar;
- MRI – musculoskeletal;
• MRI – thoracic;
• Pelvic laparoscopy;
• PET scan;
• Psychological/neuropsychological testing of more than six hours;
• Outpatient detoxification involving methadone or suboxone;
• Intensive or structured Outpatient programs; and
• Biofeedback/neurofeedback.

This list is not all-inclusive and is subject to change. You should call Cigna member services at 1-888-502-4462 to determine whether your procedure requires Precertification.

In-Network Benefits for Special Situations

The CDHP 90 has provisions for special health care situations to ensure that you can get In-Network benefits whenever possible.

Medical Care While Traveling

Emergency Care

In an Emergency situation—whether you are traveling within or outside of your network area—you or your family should call 911 or seek treatment at the nearest Emergency facility or urgent care facility. If you are enrolled in the CDHP 90, you, your family or your physician should contact Cigna member services at 1-888-502-4462 within 48 hours of receiving Emergency care.

Non-Emergency Care

If medical care is necessary, but not an Emergency and you are enrolled in the CDHP 90, you should contact Cigna member services to find out if there is an affiliated network provider in the area. If so, Cigna can refer you to Participating Providers to ensure that you receive In-Network benefits. If not, services will be reimbursed at the Out-of-Network level of benefits.

If you have a chronic condition, contact your personal physician before traveling to discuss any care requirements while you are away from home.

Medical Care for Students Outside the Network Service Area

If you are enrolled in the CDHP 90, you should contact Cigna member services to determine if there is a network in the area where your child attends school. If a local network is available, your child may use any provider in that network. Your child will receive the full range of In-Network benefits. If your child is not in a network area, follow the rules described under “Medical Care While Traveling” above.

Centers of Excellence Program

The CDHP 90 includes a “Centers of Excellence” Program, which provides access to medical facilities and staff who are experienced in specialty procedures such as organ and tissue transplants, cardiac bypass surgery, angioplasty and brain/spinal cord injuries. The CDHP 90 pays for Medically Necessary services and supplies involved with these procedures at the same benefit level as other services.

Cigna LIFESOURCE Organ Transplant Network

Cigna LIFESOURCE Organ Transplant Network is a network of nationally recognized medical centers that can provide the most appropriate care for members requiring organ or tissue transplants (including heart, heart/lung, lung, liver, kidney/pancreas and allogeneic bone marrow transplants). The Cigna LIFESOURCE Organ Transplant Network for Kids is also available to care for the special needs of children and their families. The CDHP 90 covers care and services In-Network at the 90%
Coinsurance amount after the annual Deductible and Out-of-Network at the 70% Coinsurance amount after the annual Deductible.

Transportation and lodging benefits are covered for the patient and a companion when using a Cigna LIFESOURCE facility. Travel expenses are covered up to a maximum of $10,000 per transplant, In-Network only.

**Cigna Healthy Rewards**

Through Cigna's Healthy Rewards program, Cigna offers personalized services, online features and support to participants, including offering discounts on a variety of products and services. Access to Healthy Rewards is available regardless of which Cigna Retiree Medical Program option you enroll in. You can get more information regarding Healthy Rewards through the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) or by calling Cigna member services at 1-888-502-4462.
Health Maintenance Organizations

The Retiree Medical Program offers non-Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents a Health Maintenance Organization (HMO) administered by Aetna (Aetna HMO), which features the Aetna Select provider network.

Please note: In general, the “companion coverage” benefits for non-Medicare-eligible Dependents of Medicare-eligible participants enrolled in the Aetna and UnitedHealthcare (UHC) Medicare Advantage Programs are substantially similar to the benefits described in this section. You should contact your carrier for information about program details.

If you have questions regarding your Aetna or UHC Medicare Advantage Program Companion Coverage benefits, please contact:

• For the Aetna HMO or Aetna Medicare Advantage Program Companion Coverage benefits, call 1-877-542-0726 or visit the Aetna custom website for Prudential (at www.aetna.com/docfind/custom/pruretiree); and
• For the UHC Medicare Advantage Program Companion Coverage benefits, call 1-800-443-9494 or visit the UnitedHealthcare custom website for Prudential (at www.myuhc.com/groups/prudential).

If you have questions regarding your Aetna HMO benefits, please contact Aetna at the member services number listed below or visit the Aetna custom website for Prudential:

• Aetna member services:
  Telephone: 1-877-542-0726
  Website: www.aetna.com/docfind/custom/pruretiree

Local HMOs may also be available in your area. The benefit provisions of the local HMOs vary by HMO. Although Prudential attempts to have all HMOs offer consistent benefits, the precise coverage benefits, rules and claims and appeals process will be described in summaries provided separately by the local HMO. (For the HealthPartners and Horizon HMOs, the summary is included in the HMO Appendix booklet.) If you have not received one already or need an additional copy, call the member services department of your local HMO. The Annual Enrollment materials provided during the Annual Enrollment Period show a comparison of important benefit features of each HMO. If you have difficulty locating the summary, or for availability of HMOs in your area, please call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

How the Program Works

<table>
<thead>
<tr>
<th>Aetna HMO At-A-Glance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible²</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum² (Includes annual Deductible; excludes Prescription Drug Coinsurance. For the 2013 Plan Year, excludes Hospital and emergency room Copays. For the 2014 Plan Year, includes Hospital and emergency room Copays.)</td>
</tr>
<tr>
<td>Preventive Care³</td>
</tr>
<tr>
<td>Primary Care and Specialty Care Office Visits</td>
</tr>
<tr>
<td>Coinsurance</td>
</tr>
</tbody>
</table>

Table and footnotes continue on page 132
Aetna HMO\textsuperscript{1} At-A-Glance

Mental Health and Substance Use Disorder Services\textsuperscript{4}

\begin{itemize}
\item Inpatient services: Program pays 90\% after annual Deductible is met and $150 Hospital Copay per admission
\item Outpatient services: Program pays 90\% after annual Deductible is met
\end{itemize}

\textsuperscript{1} The local HMOs may have benefits that differ. Please see your Annual Enrollment materials provided during the Annual Enrollment Period for details.

\textsuperscript{2} Prescription Drug charges do not apply toward the annual Deductible or Annual Out-of-Pocket Maximum under the Aetna HMO. Expenses you incur for inappropriate use of the emergency room do not apply against the Annual Out-of-Pocket Maximum. In addition, for claims incurred during the 2013 Plan Year, Aetna HMO Hospital and emergency room Copays did not apply against the Annual Out-of-Pocket Maximum. For the 2014 Plan Year, Hospital and emergency room Copays apply toward the Annual-Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.

\textsuperscript{3} Preventive Care benefits are subject to applicable age and frequency limits. Please contact Aetna or your local HMO for details.

\textsuperscript{4} Under the Aetna HMO, PCP referrals are not required for Mental Health and Substance Use Disorder services.

\begin{center}
\begin{tabular}{|l|c|c|c|}
\hline
\textbf{Prescription Drugs} & \textbf{Generic} & \textbf{Brand-Name Preferred} & \textbf{Brand-Name Non-Preferred} \\
\hline
\textbf{At Participating Retail Pharmacies} & \multicolumn{3}{c|}{(up to a 30-day supply)} \\
& You pay 25\% Coinsurance, subject to a $5.00 minimum\textsuperscript{3} and a $20.00 maximum & You pay 25\% Coinsurance, subject to a $25.00 minimum\textsuperscript{3} and a $45.00 maximum & You pay 40\% Coinsurance, subject to a $40.00 minimum and a $100.00 maximum \\
\hline
\textbf{Through the Express Scripts Pharmacy (home delivery)} & \multicolumn{3}{c|}{(up to a 90-day supply)} \\
& You pay 25\% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum & You pay 25\% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum & You pay 40\% Coinsurance, subject to a $80.00 minimum and a $200.00 maximum \\
\hline
\end{tabular}
\end{center}

\textsuperscript{1} The Retiree Prescription Drug Program administered by Express Scripts is available under the Aetna HMO only and is not available under the local HMOs.

\textsuperscript{2} The Retiree Prescription Drug Program covers certain preventive medications at 100\%. To receive these medications covered at 100\%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

\textsuperscript{3} At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

An HMO is designed to provide you with a full range of health care services for a modest out-of-pocket cost. Different HMOs generally offer similar types of Covered Services, Prescription Drug coverage, and Mental Health and Substance Use Disorder programs, but Copays and benefit amounts may vary by HMO.

The main difference between an HMO and your other Retiree Medical Program options (like Retiree Medical Program E – CDHP 80 or Retiree Medical Program E – CDHP 90) is that HMO coverage is provided only when you seek care from Participating Providers, and you do not need to file claim.
forms. **HMOs do not provide benefits for care received from non-Participating Providers, except in Emergencies.**

Under HMOs, you visit doctors and health care facilities that participate in the HMO’s network of Participating Providers. Each time you need care, visit a Participating Provider, pay a Copay amount, Deductible and/or Coinsurance and the HMO provides benefits for Covered Services. Local HMOs may have benefits that differ. Please see your Annual Enrollment materials provided during the Annual Enrollment Period for details.

**Your Primary Care Physician**

The Aetna HMO and most local HMOs require you to select a Primary Care Physician (PCP). Your PCP will provide most of your routine care, and coordinate care with other network providers. Once you enroll and select your PCP, you will receive an identification card with your PCP’s name or phone number on it. If you enroll in a local HMO, refer to the Annual Enrollment materials provided during the Annual Enrollment Period to determine whether a PCP selection is required.

You may select a general practitioner, family practitioner or internist as your PCP. If you are enrolling a Dependent Child, you may choose a pediatrician as your child’s PCP. You may select the same PCP for the entire family, or each family member may choose his/her own PCP.

Provider directories under each health care carrier are available separately from this SPD booklet. Provider information is available at no cost to you. If you need provider information, several sources are available:

- You will find links to many of the carriers’ websites on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com));

- Refer to the Annual Enrollment materials provided during the Annual Enrollment Period for information on how to contact your carrier directly through their website or their member services telephone number;

- To have provider information mailed to you, you can call the carrier’s member services telephone number; or

- Call the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and follow the prompts for Health and Welfare benefits.

When you enroll in the Aetna HMO or most local HMOs, you will select a PCP for you and each of your Qualified Dependents. When you enroll on the Prudential Benefits Center website, you will need to select your PCP. Shortly after you enroll, you will receive an identification card with your PCP’s name or phone number on it. **If you do not select a PCP and go to the doctor, you will not be reimbursed for any care you receive, except in Emergencies.**

**Please note:** Follow these steps prior to enrolling in the Aetna HMO:

- Visit the Aetna custom website for Prudential (at [www.aetna.com/docfind/custom/pruretiree](http://www.aetna.com/docfind/custom/pruretiree)); and

- Contact your provider to verify that he/she is accepting new patients. Aetna has several networks, so be sure to ask if your provider is part of the Aetna Select network.

You may change your PCP at any time during the year. To do so, call your carrier’s member services department and request to change your PCP. You will need to provide the new PCP’s provider number to the member services representative. Shortly after you make the change, you may receive a new identification card listing your new PCP. Any changes you make to your PCP take effect on the date you request the change. For some HMOs, PCP changes apply effective on the first of the following month or later depending upon when the change is made. Contact the HMO for more information.

If your PCP leaves the HMO mid-year, you will be notified. You will need to choose a new PCP within the 31-day period on and following notification.
**Please note:** You will not be allowed to change your Retiree Medical Program option mid-year if your PCP or a Participating Provider leaves the HMO network.

**Specialist Referrals**

If you are enrolled in the Aetna HMO, or in some cases, one of the local HMOs, and need to see a Specialist, your PCP must make the referral for you to receive In-Network benefits. If you do not get a referral from your PCP prior to seeking care from a Specialist, you will not be reimbursed for the service, except for some local HMOs that do not require a PCP referral for Specialist care. Refer to the Annual Enrollment materials provided during the Annual Enrollment Period to determine if a specialist referral is required under your local HMO.

If you are enrolled in the Aetna HMO, you do not need a referral from your PCP for Mental Health or Substance Use Disorder treatment. To find a list of Participating Providers, you may visit the Aetna custom website for Prudential at [www.aetna.com/docfind/custom/pruretiree](http://www.aetna.com/docfind/custom/pruretiree) for a directory of health care professionals and facilities or call Aetna member services at 1-877-542-0726.

For many HMOs, your PCP’s office will make the referral for you if you are seeking Specialist care. Depending on your diagnosis, your PCP may make a referral for one visit, or may request a “standing referral” for a number of visits or treatments.

There is another important exception to the PCP referral: For the Aetna HMO and the local HMOs, women do not need a referral to see an In-Network OB/GYN for an annual well-woman exam, or for general obstetrical or gynecological care, including follow-up care or mammograms (although you do need a prescription for a mammogram). However, a referral would be needed for specialty care, such as infertility treatment.

Conversely, some HMOs allow women to choose an OB/GYN as their second PCP. Contact your HMO directly if you have any questions about Specialist referrals or OB/GYN care.

**Your Annual Deductible**

When you receive care or services (other than Preventive Care), you must meet an individual or family annual Deductible before the Aetna HMO will pay benefits.

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, the Aetna HMO will pay any Covered Expenses at the benefits level for the rest of that Calendar Year.

**Please note:** Prescription Drug charges and expenses you incur for inappropriate use of the emergency room will not apply against the annual Deductible.

**Individual Annual Deductible**

The individual annual Deductible is $200 per Calendar Year.

The individual annual Deductible applies if you have You Only coverage. Your out-of-pocket expenses must total the individual annual Deductible before Coinsurance begins.

If you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage, each individual will need to pay $200 out-of-pocket (or $400 per family), before the program begins to pay eligible benefit expenses.

**Family Annual Deductible**

If you are covering Qualified Dependents, the family annual Deductible is $400 per Calendar Year.

The family annual Deductible applies if you have You + Spouse/Qualified Adult, You + Child(ren) or You + Family coverage.

If you are covering one or more Qualified Dependents, the family annual Deductible will be met when any combination of eligible out-of-pocket expenses incurred by you and your Covered Qualified Dependents reaches $400.
For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $100 Eligible Expense, then your child incurs a $100 Eligible Expense, and then your Spouse incurs a $300 Eligible Expense. The Eligible Expenses of all family members add up to $500. As a result, your $400 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $300 expense, the first $200 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the 90% Coinsurance level.

**Annual Out-of-Pocket Maximum**

The Aetna HMO's Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury.

**Please note:** Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under the Aetna HMO. In addition, for claims incurred during the 2013 Plan Year, Aetna HMO Hospital and emergency room Copays and expenses you incur for inappropriate use of the emergency room did not apply against the Out-of-Pocket Maximum. For the 2014 Plan Year, Aetna HMO Hospital and emergency room Copays apply toward the Annual Out-of-Pocket Maximum.

**Individual Annual Out-of-Pocket Maximum**

The individual Annual Out-of-Pocket Maximum under the Aetna HMO is $1,400 per Calendar Year. The maximum includes your annual Deductible and all expenses subject to Coinsurance. Effective January 1, 2014, the Annual Out-of-Pocket Maximum also includes Copays.

Once any covered individual's out-of-pocket expenses reach the individual maximum, the Aetna HMO will pay 100% for any further Eligible Expenses incurred by that individual for the rest of the Calendar Year.

**Please note:** There are exceptions to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” on page 143 after the individual Annual Out-of-Pocket Maximum is met. Prescription Drug Coinsurance does not apply toward the Annual Out-of-Pocket Maximum. In addition, for claims incurred during the 2013 Plan Year, you were responsible for paying Copays even after the individual Annual Out-of-Pocket Maximum was reached.

**Family Annual Out-of-Pocket Maximum**

The family Annual Out-of-Pocket Maximum under the Aetna HMO is $2,800 per Calendar Year. The family maximum will be met when any combination of Eligible Expenses incurred by you and your Covered Qualified Dependents reaches the family out-of-pocket limit.

The maximum includes your annual Deductible and all medical expenses subject to Coinsurance. Effective January 1, 2014, the Annual Out-of-Pocket Maximum also includes Copays.

Once your out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, the Aetna HMO will pay 100% for any further Eligible Expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

**Please note:** There are exceptions to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” on page 143 after the family Annual Out-of-Pocket Maximum is met. Prescription Drug Coinsurance does not apply toward the Annual Out-of-Pocket Maximum. In addition, for claims incurred during the 2013 Plan Year, you were responsible for paying Copays even after the individual Annual Out-of-Pocket Maximum was reached.

**Covered Services**

The Aetna HMO covers a wide variety of services as long as the services are Medically Necessary. The list of Covered Services described beginning on page 136 is not all-inclusive and is subject to change. Covered Services under the local HMOs may vary. If you have questions about your coverage, please
contact your HMO directly for more information. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

The Aetna HMO care and services include, but are not limited to:

**Preventive Care**

You are encouraged to contact your PCP to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Aetna member services at 1-877-542-0726 or visit the Aetna custom website for Prudential at www.aetna.com/docfind/custom/pruretiree to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Most Preventive Care services are covered at 100%. The annual Deductible does not apply to Preventive Care services. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care;
- Immunizations;
- Colonoscopies (and related services);
- Adult routine physicals:
  - X-ray and lab services are covered at 100% when incurred as a result of a routine physical. This includes charges billed by a physician's office, an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age or frequency limitations. Contact Aetna for more information;
- Well-woman care:
  - Anemia screening on a routine basis for pregnant women;
  - Bacteriuria urinary tract or other infection screening for pregnant women;
  - For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;
  - Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;
  - Breast cancer mammography screenings every one to two years for women over age 40;
  - Breast cancer chemoprevention counseling for women at higher risk;
  - Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;
  - Cervical cancer screening (Pap-tests) for sexually active women;
  - Chlamydia infection screening for younger women and other women at higher risk;
  - Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;
  - Domestic and interpersonal violence screening and counseling for all women;
— Folic acid supplements for women who may become pregnant;
— Gestational diabetes screening;
  — For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24
to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  — Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic
pregnant women after 24 weeks of gestation;
— Gonorrhea screening for all women at higher risk;
— Hepatitis B screening for pregnant women at their first prenatal visit;
— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;
— Human Papillomavirus (HPV) DNA testing;
— Osteoporosis screening for women over age 60 depending on risk factors;
— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher
risk;
— Sexually transmitted infection (STI) counseling for sexually active women;
— Syphilis screening for all pregnant women or other women at increased risk;
— Tobacco use screening and interventions for all women, and expanded counseling for pregnant
tobacco users; and
— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 100% when incurred as a
result of a routine physical. This includes charges billed by a physician’s office, an independent lab
or x-ray facility or Outpatient Hospital facility.

Preventive Care services may be subject to certain age and/or frequency limitations. Contact Aetna for
more information.

**Office Visits**

Office Visits for purposes other than Preventive Care are covered at 90% after you meet the annual
Deductible and include:

— Office Visits (PCP and Specialists);
— Maternity care (90% Coinsurance after you meet the annual Deductible applies to the initial visit as
well as the global maternity charge for delivery and pre- and post-natal care):
  — Some prenatal services are covered at 100%. Please see the “Preventive Care” section beginning
on page 136 for more details; and
  — Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an
initial evaluation and to establish a prenatal care schedule. Visit the Aetna custom website for
Prudential at [www.aetna.com/docfind/custom/pruretiree](http://www.aetna.com/docfind/custom/pruretiree)
to learn more about pregnancy
guidelines, based on recommendations from the American College of Obstetricians and
Gynecologists;
— Physical, occupational and speech therapy is covered at 90% after you meet the annual Deductible
(this includes cognitive therapy and cardiac and pulmonary rehabilitation):
— **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

- Chiropractic care is covered at 90% after you meet the annual Deductible (maximum of 60 visits per Calendar Year); and

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Hospital Services**

Hospital services are covered at 90% after you meet the annual Deductible and $150 Hospital Copay per admission. Covered Services include:

- Inpatient Hospital stay (90% after you meet the annual Deductible and $150 Hospital Copay per admission);

- Surgery (Inpatient and Outpatient);

- Semi-private room and board at the Hospital (included under Inpatient Hospital stay);

- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);

- Pre-admission testing;

- Outpatient facility and supplies;

- Physical, occupational and speech therapy (Inpatient and Outpatient services are covered at 90% after you meet the annual Deductible):
  
  — Includes cognitive therapy and cardiac and pulmonary rehabilitation; and

  — **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;

- Ambulance services if Medically Necessary; and

- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment (90% after you meet the annual Deductible and $150 Hospital Copay per admission).

**Other Covered Services**

Other Covered Services are covered at 90% after you meet the annual Deductible and include:

- X-ray and lab services (when not in connection with Preventive Care);

- Obstetrician’s charge for maternity care, including delivery;

- Delivery care and services at a Hospital or birthing center;

- Skilled nursing facility (100 day maximum per Calendar Year);

- Home Health Care:
  
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and

  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.
In addition to visits by a home health agency in a person's home, the program covers:

- Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;
- Home health aid services;
- Physical, occupational or speech therapy by a qualified therapist;
- Dietary counseling;
- Medical social services;
- Medical supplies, drugs and medicines prescribed by a physician;
- Lab services (provided by or for a Home Health Care agency); and
- Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

- Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;
- Services that do not require the technical skills of a medical, Mental Health or dental professional;
- Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;
- Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
- Transportation services;
- Services and supplies not Medically Necessary; and
- Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.

If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

- Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;
- Infertility treatment (including coverage for pre-work to diagnose the cause of infertility for eligible participants and treatment to surgically correct the underlying medical cause of infertility; there is a $20,000 lifetime maximum):
— Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” on page 143 for more information;

— Infertility procedures are covered if:

  - A female member is unable to conceive or produce conception after:
    - One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;
    - Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or
    - At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);
  - The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, a network infertility specialist and the physician who diagnosed the member as infertile;
  - The procedures are done while not confined in a Hospital or any other facility as an Inpatient;
  - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
  - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;
  - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and
  - The member has attempted less costly medically appropriate treatment for which coverage is available under this Program; or
  - The member has a newly diagnosed cancer and has planned cancer treatment that includes a therapy recognized to result in infertility; and
    - The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;
    - Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle; and
    - The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal).

— For more information, check the Aetna HMO schedule of benefits regarding infertility treatment coverage. A schedule of benefits may be obtained from the Aetna HMO’s website or clinical policy, or by contacting Aetna directly. Coverage information is available at no cost to any participant or beneficiary who requests it;

- Durable medical and surgical equipment (for example, crutches, wheelchairs, braces). For more information, check your HMO’s schedule of benefits regarding coverage for durable medical and surgical equipment. The schedule of benefits may be obtained from your HMO provider’s website or clinical policy, or by contacting your HMO directly. Coverage information is available at no cost to any participant or beneficiary who requests it;
• Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to treatment to accidental injury of sound, natural teeth sustained while covered under the Aetna HMO or for surgical removal of a tumor);

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program;

• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes services to aid in smoking cessation, including:
  — Preventive counseling visits (maximum of eight visits per 12 months);
  — Treatment visits; and
  — Class visits; and

• Sleep studies.

Some services routinely require determination by Aetna that the services are Medically Necessary. Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification and certain conditions; contact your carrier for details).

For more information, please contact Aetna. Coverage will be provided according to Aetna’s standard coverage policies and procedures. Coverage information is available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;

• Abdominoplasty;

• Panniculectomy;

• Redundant skin surgery;

• Removal of skin tags;

• Craniosacral/cranial therapy;

• Dance therapy;

• Movement therapy;

• Applied kinesiology;

• Prolotherapy;

• Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions;

• Special vision procedures, such as orthoptics, vision therapy or vision training, for specific conditions;

• Transportation services;
- Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a case-by-case basis; excludes orthodontic treatment);

- Removal of an implant that alters the appearance of the body (such as breast or chin implants);

- Orthopedic footwear;

- Footwear to accommodate a diabetic condition;

- Surgical treatment of varicose veins;

- Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in connection with surgery that is covered under the Retiree Medical Program option;

- Home uterine activity monitoring; and

- Biofeedback and bioenergetic therapy.

For a list of services not covered, see “Coverage Exclusions” beginning on page 172.

**In Case of Emergency**

For the Aetna HMO, if you have a medical Emergency, defined as an illness or injury that could cause serious bodily harm if not treated immediately, you should go to the nearest Hospital emergency room or urgent care facility. You do not have to call your PCP first to get Emergency care. Once you have the care you need, you or your family should contact your PCP as soon as possible to advise of the occurrence and to arrange for follow-up care. Please note that referrals are required for follow-up care following Emergency care.

If you are admitted to the Hospital, the emergency room Copay is waived and Emergency benefits are paid at the In-Network benefits level (90% after you meet the annual Deductible and $150 Hospital Copay per admission), whether you use an In-Network or an Out-of-Network facility.

Each HMO has its own definition and special provisions for Emergency care, which vary among the local HMOs. Contact the HMO for more information.

**Emergency Care Benefits At-A-Glance**

| Aetna HMO¹ | Use of emergency room (for a true Emergency) | Program pays 90% after annual Deductible is met and $150 Copay (emergency room Copay is waived if admitted to Hospital) |
| Use of emergency room (for routine or non-Emergency care) | Program pays 50% of Covered Charges after annual Deductible is met |
| Use of urgent care facility (for an Urgent Condition) | Program pays 90% after annual Deductible is met |
| Use of urgent care facility (for a non-Urgent Condition) | Not covered |
| Ambulance service (for a true Emergency) | Program pays 90% of Covered Charges after annual Deductible is met |
| Ambulance service (for routine or non-Emergency care) | Not covered² |

¹ The local HMOs may have benefits that differ. Please see your Annual Enrollment materials provided during the Annual Enrollment Period for details.

² Ground ambulance support is covered if Medically Necessary, such as for transporting a patient from one Hospital to another. Contact Aetna for details.
Prescription Drug Benefits

All of the HMOs that Prudential offers provide Prescription Drug coverage.

If you enroll in the Aetna HMO, you will have access to the participating retail pharmacy program and home delivery drug program under the Retiree Prescription Drug Program administered by Express Scripts. If you enroll in the Aetna HMO, you will be enrolled automatically in the Retiree Prescription Drug Program.

Participants in the local HMOs are not eligible for the Retiree Prescription Drug Program administered by Express Scripts. The local HMOs may have benefits that differ. Please see your Annual Enrollment materials provided during the Annual Enrollment Period for details.

Under the Aetna HMO, you must purchase Prescription Drugs through the network of participating retail pharmacies or by using the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar minimums and maximums as the table below illustrates.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retiree Prescription Drug Program Administered by Express Scripts¹</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Generic</td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum² and a $20.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
</tbody>
</table>

¹ The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

² At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

Other Important Features

<table>
<thead>
<tr>
<th>Fertility Drugs (Oral and Injectables)</th>
<th>Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$6,000 Maximum Lifetime Benefit (this limit is combined for retail and the Express Scripts Pharmacy home delivery prescriptions)</td>
</tr>
</tbody>
</table>

Your local HMO may cover certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating mail or retail pharmacy. For more information, please contact your local HMO.

For more information about the Retiree Prescription Drug Program administered by Express Scripts, see “The Retiree Prescription Drug Program” beginning on page 31.

For information about the Prescription Drug benefits under the local HMOs, contact the HMO directly by calling the telephone number on your identification card.
**Precertification Rules**

Precertification is an important tool in managing the quality and expense of Inpatient Hospital and facility admissions and certain Outpatient procedures and tests. Your Provider must call the toll-free number listed on your identification card to precertify Hospital admissions and certain Outpatient procedures and tests, as required by the Aetna HMO (see also “In Case of Emergency” on page 142 for more information). Failure to do so may affect your benefits. In an Emergency, seek care immediately, then call your physician within 48 hours for further assistance and directions on follow-up care.

<table>
<thead>
<tr>
<th>Precertification Rules At-A-Glance</th>
<th>Aetna HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who should call</strong></td>
<td>Your Participating Provider</td>
</tr>
<tr>
<td><strong>Where to call</strong></td>
<td>Aetna 1-877-542-0726</td>
</tr>
<tr>
<td><strong>When to call</strong></td>
<td>Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) or Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder, within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program)</td>
</tr>
<tr>
<td>If your Provider calls to precertify, and care is determined not Medically Necessary</td>
<td>No coverage</td>
</tr>
<tr>
<td>If your Provider does not call to precertify, but care is Medically Necessary</td>
<td>There is no member penalty for failure to precertify</td>
</tr>
<tr>
<td>If your Provider does not call to precertify, and care is not Medically Necessary</td>
<td>No coverage</td>
</tr>
</tbody>
</table>

Your Participating Provider must contact Aetna patient management to request Precertification of your care. **Please note:** The Aetna HMO does not provide benefits for care received from non-Participating Providers, except in Emergencies.

Different Precertification requirements may apply under the local HMOs. Most local HMOs require prior authorization for select services. Please contact your carrier to determine if you are responsible for obtaining this approval or if your Participating Provider will coordinate on your behalf.

**Services Requiring Precertification**

Precertification is required for all Inpatient confinements. In addition, the following Outpatient procedures and services require Precertification under the Aetna HMO:

- Procedures and services provided through the following treatment facilities and programs for mental disorders and Substance Use Disorders:
  - Residential Treatment Centers;
  - Partial Hospitalization Programs; and
  - Intensive Outpatient Programs;

- Reconstructive or other procedures that may be considered cosmetic;

- Artificial intervertebral disc surgery;
• Lumbar spinal fusion surgery;
• Uvulopalatopharyngoplasty, including laser-assisted procedures;
• Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
• Outpatient surgical scopes (for example, bronchoscopy, colonoscopy, cystoscopy, hysteroscopy, knee arthroscopy, laparoscopic cholecystectomy, shoulder arthroscopy, and upper GI endoscopy);
• Autologous chondrocyte Implantation, Carticel®;
• Cochlear device and/or implantation;
• Cognitive skills development;
• Dorsal column (lumbar) neurostimulators: trial or implantation;
• GI tract imaging through capsule endoscopy;
• Hyperbaric oxygen therapy;
• Negative pressure wound therapy;
• Onco type DX;
• Osseointegrated implant;
• Osteochondral allograft/knee;
• Ventricular assist devices;
• Sleep studies within Hospitals or freestanding facilities;
• Home Health Care related services;
• Selected durable medical equipment;
• Dialysis visits;
• Genetic testing;
• Infertility services;
• Outpatient imaging precertification for computed tomographic (CT) studies, coronary CT angiography, MRI/MRA, nuclear cardiology, PET scans, diagnostic left and right heart catheterizations and echo stress tests; and
• Elective cardiac rhythm implantable devices.

This list is not all-inclusive and is subject to change. You should call Aetna member services at 1-877-542-0726 to determine whether your procedure requires Precertification.

Filing Claims
There are no claim forms to file for In-Network care under the HMO programs. Your provider will submit claims directly to the HMO on your behalf.

If you receive Emergency care outside the HMO network area, contact your HMO for information about how to file for reimbursement.
To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim.

If your claim is denied, you have the right to appeal the decision. Contact your HMO for information on how to appeal a denied benefits claim. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.)

**Benefits for Special Situations**

The Aetna HMO, as well as some local HMOs, has provisions for special health care situations to ensure you receive In-Network benefits whenever appropriate.

**Medical Care While Traveling**

**Emergency Care**

In an Emergency situation—whether you are traveling within or outside of your network area—you or your family should call 911 or seek treatment at the nearest Emergency facility or urgent care facility. If you are enrolled in the Aetna HMO, you or your family should contact your PCP as soon as possible after receiving Emergency care.

**Non-Emergency Care**

If medical care is necessary, but not an Emergency and you are enrolled in the Aetna HMO, you must contact Aetna member services to find out if there is an affiliated network provider in the area. If so, member services may refer you to Participating Providers to ensure that you receive In-Network benefits. However, PCP referrals may be required. You may not see a non-Participating Provider and receive In-Network benefits. Services rendered by non-Participating Providers in non-Emergency situations are generally not covered.

If you have a chronic condition, contact Aetna member services before traveling to discuss In-Network coverage alternatives.

**Medical Care for Students Outside the Network Service Area**

If you are enrolled in the Aetna HMO, you should contact Aetna member services to determine if there is a network in the area where your Dependent Child attends school. If a local network is available, member services can assist with guesting your Dependent Child into this network. Guesting allows your Dependent Child to utilize a different network to receive In-Network benefits. If your child is not in a network area, coverage is only provided in Emergency situations. Follow the rules described under “Medical Care While Traveling” above.

**Aetna HMO's Institutes of Excellence Program**

The Aetna HMO, as well as some local HMOs, include “Institutes of Excellence” Programs, which provide access to medical facilities and staff who are experienced in specialty procedures such as organ and tissue transplants, cardiac bypass surgery, angioplasty and brain/spinal cord injuries. The Program pays for Covered Services and supplies involved with these procedures at the same HMO benefit levels as other services.

**Aetna’s National Medical Excellence Program**

Aetna's National Medical Excellence Program coordinates specialty care with nationally respected doctors and Hospitals. The Aetna HMO covers care and services at 90% after you meet the annual Deductible. For Inpatient stays, the $150 Hospital Copay per admission also applies. The Aetna HMO only covers Institutes of Excellence network facilities.

The Program includes:

- The National Transplantation Program, which helps to arrange care for organ and tissue transplants (including heart, heart/lung, lung, liver, kidney, pancreas, peripheral stem cell and bone marrow transplants). The network level of benefits is paid only for a treatment received at a facility designated by the plan as an Institute of Excellence (IOE) for the type of transplant being performed. Each IOE facility has been selected to perform only certain types of transplants.
Services obtained from a facility that is not designated as an IOE for the transplant being performed will be covered as out-of-network services and supplies, even if the facility is a network facility or IOE for other types of services;

- When significant travel is required to use an IOE facility, the member may be eligible for travel and lodging allowances, according to Aetna’s standard internal policies and procedures;
- The National Special Case Program, which evaluates and helps arrange complex care including cardiac, neurosurgical and other complex specialized care; and
- The Out-of-Country Care Program, which helps members who need Emergency and urgent medical care while traveling outside the country.

If you have questions or need additional information about similar services that may be available through your local HMO or the UHC Medicare Advantage Program Companion Coverage benefits, please contact your medical carrier.

**Disease Management Programs**

Disease management programs can help you and Prudential manage the cost and effectiveness of the care you (or one of your Qualified Dependents) receive for certain chronic conditions. Such chronic conditions may include, but are not limited to, asthma, heart disease, diabetes and lower back pain. Disease management programs are voluntary and are available at no cost to you.

Please note: Through the disease management programs offered by your Retiree Medical Program option, either your health care carrier or a sub-contracted vendor may reach out to you regarding your disease state, based on claims that you have submitted to your medical carrier.

If you have questions or need additional information about disease management programs, contact your medical carrier directly.

**Health Connections Disease Management Programs for the Aetna HMO**

The Aetna HMO offers disease/condition management programs. Through these programs, a Registered Nurse can provide you or one of your Qualified Dependents with more information about their condition and explain the treatment the participant’s physician has recommended, including how to monitor the condition. In addition, the nurse can coordinate the care a participant needs with the physician and help with strategies for self-management of more than 30 conditions, including diabetes, cancer and heart disease.

If you (or a Qualified Dependent) have an ongoing health condition, Aetna’s disease management program can help you:

- Know how to get the treatment and Preventive Care you need;
- Understand how to follow your doctor’s treatment plan;
- Manage your ongoing conditions well;
- Make changes to reach your personal health goals; and
- Identify and manage your risks for other conditions.

The program offers support for more than 30 medical conditions. Aetna’s nurses and clinicians can support you even if you have more than one condition—all in one program. You’ll have one person who can help you no matter how many conditions you have. Plus, you have access to:

- Educational materials and online resources;
- Nurse case management if you’re high risk; and
• State-of-the-art technology that looks out for your health and safety.

If you are an Aetna member and have an ongoing health condition, call 1-866-269-4500 to get started. Disease management programs are voluntary and are available at no cost to you.

**Disease Management Programs for the Local HMOs**

Disease management programs may also be available under some of the local HMOs. Contact your HMO directly for more information.

**Aetna Extras**

Through Aetna Extras, Aetna offers personalized services, online features and support to participants, including offering discounts on a variety of products and services. Access to Aetna Extras is available if you enroll in the Aetna HMO or a Retiree Dental Program option. You can get more information regarding Aetna Extras through the Aetna custom website for Prudential at [www.aetna.com/docfind/custom/pruretiree](http://www.aetna.com/docfind/custom/pruretiree) or by calling Aetna member services at 1-877-542-0726.
Retiree Medical Program E – Indemnity

This program option is available to all Retirees, Long Term Disability participants and Surviving Dependents who are Medicare-eligible. For Retirees, Long Term Disability participants and Surviving Dependents who are not Medicare-eligible and who reside in Hawaii, Retiree Medical Program E – Indemnity is also available.

Retiree Medical Program E – Indemnity is a traditional Indemnity program administered by Cigna HealthCare (Cigna).

If you have questions regarding your benefits, please contact Cigna at the member services number listed below or visit the Cigna custom website for Prudential:

- Cigna member services:
  Telephone: 1-888-502-4462
  Website: www.cigna.com/prudential

How the Program Works

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<th>Retiree Medical Program E – Indemnity&lt;sup&gt;1&lt;/sup&gt; At-A-Glance</th>
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<td><strong>Annual Deductible&lt;sup&gt;2&lt;/sup&gt;</strong></td>
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<td><strong>Annual Out-of-Pocket Maximum&lt;sup&gt;2&lt;/sup&gt;</strong> (includes annual Deductible)</td>
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<td><strong>Preventive Care&lt;sup&gt;3&lt;/sup&gt;</strong></td>
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</table>

<sup>1</sup> Certain benefit provisions differ for participants residing in Hawaii. Please contact Cigna for details.

<sup>2</sup> Prescription Drug charges do not apply toward the annual Deductible or the Annual Out-of-Pocket Maximum under Retiree Medical Program E – Indemnity. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization, will not apply against the annual Deductible or the Annual Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.

<sup>3</sup> Preventive Care benefits are subject to applicable age and frequency limits. Please contact Cigna for details.

Prescription Drugs

<table>
<thead>
<tr>
<th>Retiree Prescription Drug Program Administered by Express Scripts&lt;sup&gt;1&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic</strong></td>
</tr>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
</tr>
</tbody>
</table>

Table and footnotes continue on page 150
Prescription Drugs
Retiree Prescription Drug Program Administered by Express Scripts

<table>
<thead>
<tr>
<th></th>
<th>Generic</th>
<th>Brand-Name Preferred</th>
<th>Brand-Name Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
<td>You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
<td>You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

1 The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

2 At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table beginning on page 149, you will pay the lower amount.

Retiree Medical Program E – Indemnity is a comprehensive medical program providing a broad scope of features and benefits. It is designed for all Medicare-eligible participants and for participants living in Hawaii who are not eligible for Medicare.

You can visit any doctor or health care facility, but you are responsible for submitting a claim form for reimbursement. Eligible Preventive Care services are not subject to the annual Deductible and are covered at 100%. For most other services, you need to meet an annual Deductible amount before Retiree Medical Program E – Indemnity starts to pay a percentage, called Coinsurance, of your covered health care expenses. If your costs for care reach Retiree Medical Program E – Indemnity’s Annual Out-of-Pocket Maximum, the Program will pay 100% of your covered costs for the rest of the Calendar Year.

When you enroll in Retiree Medical Program E – Indemnity, you will receive an identification card. Separately, you will receive an identification card from Express Scripts (your identification card may refer to Medco) for the Retiree Prescription Drug Program showing your Prescription Drug Coinsurance percentages (and minimum and maximum amounts).

Your Annual Deductible

When you receive care, you must meet an individual or family annual Deductible before the Program will pay benefits. The annual Deductible is:

- $500 per individual ($250 per individual if you reside in Hawaii); and
- $1,000 per family ($750 per family if you reside in Hawaii).

The annual Deductible applies only once in a Calendar Year, even if you have several different illnesses or injuries during the Calendar Year. Once the annual Deductible has been met in a Calendar Year, Retiree Medical Program E – Indemnity will pay any Covered Expenses for the rest of that Calendar Year at the Coinsurance level, up to Reasonable and Customary (R&C) limits. (See “Reasonable and Customary Fees” on page 151 for more information.) Any charges above the R&C limits cannot be applied to the annual Deductible.

For example, suppose you elect You + Family coverage. Assume that, during the Calendar Year, you incur a $400 Eligible Expense, then your child incurs a $300 Eligible Expense, and then your Spouse incurs a $500 Eligible Expense. The Eligible Expenses of all family members add up to $1,200. As a result, your $1,000 family annual Deductible will have been met, and benefits for all family members will be payable for the rest of the Calendar Year. When your Spouse incurred the $500 expense, the first $300 would have gone toward meeting the annual Deductible, and the balance would be reimbursed at the 80% Coinsurance level.
Please note: Prescription Drug charges do not apply toward the annual Deductible under Retiree Medical Program E – Indemnity. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the annual Deductible.

Coinsurance

Once you have met your annual Deductible, you and Retiree Medical Program E – Indemnity share in the cost of medical care and services through Coinsurance. Retiree Medical Program E – Indemnity pays 80% (except for Preventive Care services) and you pay 20% of the R&C Fees for Covered Services.

Reasonable and Customary Fees

Reasonable and Customary (R&C) Fees are estimates of the typical charges for similar medical care and services within a specific geographic area. Under Retiree Medical Program E – Indemnity, the R&C Fee is the amount that the Program will consider for payment of a Medically Necessary expense.

If your provider charges more than the R&C Fee, the actual amount above R&C Fees cannot be applied toward your annual Deductible. In addition, Retiree Medical Program E – Indemnity Coinsurance will cover 80% of the R&C Fee only; you will be responsible for your share of the Coinsurance, plus any amount in excess of the R&C Fees.

For example, suppose your provider charges $1,000 for a surgical expense, and the R&C Fee is $900. Assuming you have met your annual Deductible, your Retiree Medical Program E – Indemnity coverage will pay 80% of the $900 R&C Fee, or $720. You will pay the remaining 20% of the $900 R&C Fee, or $180, plus the $100 difference between the R&C Fee and the actual charge. Your total out-of-pocket cost will be $280.

Annual Out-of-Pocket Maximum

Retiree Medical Program E – Indemnity’s Annual Out-of-Pocket Maximum limits the expenses you and your Covered Qualified Dependents will have to pay each Calendar Year out of your own pocket. This maximum is protection for you and your family against the high costs of a major illness or injury.

Please note: Prescription Drug charges do not apply toward the Annual Out-of-Pocket Maximum under Retiree Medical Program E – Indemnity. In addition, amounts in excess of R&C Fees and penalty amounts such as for failure to precertify your hospitalization and/or your Outpatient surgery, will not apply against the Annual Out-of-Pocket Maximum.

Individual Annual Out-of-Pocket Maximum

The individual Annual Out-of-Pocket Maximum is $3,000 per Calendar Year ($2,000 per Calendar Year if you reside in Hawaii). The maximum includes your annual Deductible and all expenses subject to Coinsurance.

Once any covered individual’s out-of-pocket expenses reach the individual maximum, Retiree Medical Program E – Indemnity will pay 100% of the R&C Fee for any further Eligible Expenses incurred by that individual for the rest of the Calendar Year. All other covered individuals will still be responsible for a portion of their Eligible Expenses if they have not reached the Annual Out-of-Pocket Maximum.

Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 158 after the individual Annual Out-of-Pocket Maximum is met.

Family Annual Out-of-Pocket Maximum

The family Annual Out-of-Pocket Maximum is $6,000 per Calendar Year. The family maximum will be met when any combination of Eligible Expenses incurred by you and your Covered Qualified Dependents reaches the family out-of-pocket limit.

The maximum includes your annual Deductible and all expenses subject to Coinsurance.
Once your out-of-pocket expenses reach the family Annual Out-of-Pocket Maximum, Retiree Medical Program E – Indemnity will pay 100% of the R&C Fee for any further Eligible Expenses for the rest of the Calendar Year for you and your Covered Qualified Dependents.

Please note: There is an exception to the 100% coverage: Prescription Drug charges continue to be covered as described under “Prescription Drug Benefits” beginning on page 158 after the family Annual Out-of-Pocket Maximum is met.

**Maximum Lifetime Benefit for Infertility Treatment**

There is a Maximum Lifetime Benefit of $20,000 for infertility treatment. Prescription Drug expenses for infertility treatment are covered under the Retiree Prescription Drug Program administered by Express Scripts and have a separate $6,000 lifetime maximum that does not apply towards Retiree Medical Program E – Indemnity’s infertility treatment Maximum Lifetime Benefit.

**Covered Services**

The list of Covered Services described beginning below is not all-inclusive and is subject to change. If you have a question about your coverage, contact Cigna member services. For information regarding services not covered, see “Coverage Exclusions” beginning on page 172.

Benefits differ for participants residing in Hawaii. Please contact Cigna for details. Retiree Medical Program E – Indemnity care and services include, but are not limited to:

**Preventive Care**

You are encouraged to contact your Primary Care Physician (PCP) to take advantage of the Preventive Care services that are offered through your Retiree Medical Program option. The list of covered Preventive Care services is continually evolving and is subject to change. Please call Cigna member services at 1-888-502-4462 or visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about the Preventive Care guidelines that may affect you and your Covered Qualified Dependents.

Preventive Care services are covered at 100% of the R&C Fees. The annual Deductible does not apply to Preventive Care services. Preventive Care services are subject to limitations, such as age and frequency limitations, and include:

- Well-child care and immunizations, including travel immunizations (100% of the R&C Fees, no annual Deductible);

- Colonoscopies (including related services):
  - Please note: Prudential covers all colonoscopies and the ancillary services (for example, anesthesia, consultation) at 100% of the R&C Fees, regardless of whether the screening is preventive or diagnostic. If the ancillary services are not paid at 100%, usually due to billing timing issues, contact Cigna member services at 1-888-502-4462 and they will reprocess the claim accordingly;

- Adult routine physicals (100% of the R&C Fees, no annual Deductible):
  - X-ray and lab services, such as Pap-tests and mammograms, are covered at 100% of the R&C Fees, no annual Deductible when incurred as a result of a routine physical or at 80% of the R&C Fees after the annual Deductible if billed as non-preventive care. This includes charges billed by a physician's office, or an independent lab or x-ray facility or Outpatient Hospital facility; and
  - Routine physicals may be subject to certain age and/or frequency limitations. Contact Cigna for more information;

- Well-woman care (100% of the R&C Fees, no annual Deductible):
  - Anemia screening on a routine basis for pregnant women;
— Bacteriuria urinary tract or other infection screening for pregnant women;

— For claims incurred during the 2013 Plan Year, BRCA counseling about genetic testing for women at higher risk;

— Effective December 2013, screening for women who have family members with breast, ovarian, tubal or peritoneal cancer. Following positive screening results, BRCA genetic counseling and, if indicated after counseling, BRCA testing;

— Breast cancer mammography screenings every one to two years for women over age 40;

— Breast cancer chemoprevention counseling for women at higher risk;

— Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women;

— Cervical cancer screening (Pap-tests) for sexually active women;

— Chlamydia infection screening for younger women and other women at higher risk;

— Contraception: FDA-approved contraceptive methods, sterilization procedures and patient education and counseling, not including abortifacient drugs;

— Domestic and interpersonal violence screening and counseling for all women;

— Folic acid supplements for women who may become pregnant;

— Gestational diabetes screening;
  — For claims incurred during the 2013 Plan Year, gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes; and
  — Effective January 1, 2014, screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation;

— Gonorrhea screening for all women at higher risk;

— Hepatitis B screening for pregnant women at their first prenatal visit;

— Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women;

— Human Papillomavirus (HPV) DNA testing;

— Osteoporosis screening for women over age 60 depending on risk factors;

— Rh incompatibility screening for all pregnant women and follow-up testing for women at higher risk;

— Sexually transmitted infection (STI) counseling for sexually active women;

— Syphilis screening for all pregnant women or other women at increased risk;

— Tobacco use screening and interventions for all women, and expanded counseling for pregnant tobacco users; and

— Well-woman visits to obtain recommended preventive services.

X-ray and lab services, such as Pap-tests and mammograms, are covered at 100%, no annual Deductible when incurred as a result of a routine physical (this includes charges billed by a
physician’s office, or an independent lab or x-ray facility or Outpatient Hospital facility) or at 80% of the R&C Fees after the annual Deductible if billed as non-preventive care. Preventive Care services may be subject to certain age and/or frequency limitations. Contact Cigna for more information.

**Office Visits**

- Non-preventive x-ray and lab services (80% of the R&C Fees after the annual Deductible);
- Office Visits (primary care and Specialists, 80% of the R&C Fees after the annual Deductible);
- Maternity care (80% of the R&C Fees after the annual Deductible):
  - Some prenatal services are covered at 100%. Please see the “Preventive Care” section beginning on page 152 for more details; and
  - Pregnant women should visit their doctor or OB/GYN in their first trimester of pregnancy for an initial evaluation and to establish a prenatal care schedule. Visit the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) to learn more about pregnancy guidelines, based on recommendations from the American College of Obstetricians and Gynecologists;
- Physical, speech and occupational therapy (80% of the R&C Fees after the annual Deductible, up to a maximum of 90 days per Calendar Year; combined for all types of therapies or up to a maximum of 60 days per Calendar Year for each type of therapy in Hawaii only):
  - Includes cognitive therapy and cardiac and pulmonary rehabilitation; and
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Chiropractic care (80% of the R&C Fees after the annual Deductible, up to 60 days per Calendar Year if Medically Necessary); and
- Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment (80% of the R&C Fees after the annual Deductible).

**Hospital Services**

After you meet the annual Deductible, Hospital care and services are covered at 80% of the R&C Fees for the rest of that Calendar Year. Covered care and services include:

- Surgery (Inpatient and Outpatient);
- Semi-private room and board at the Hospital;
- Intensive care and other Inpatient Hospital services (convenience items, such as televisions, are not covered);
- Outpatient pre-admission testing (Office Visit or Outpatient facility);
- Outpatient facility and supplies;
- Physical, occupational and speech therapy in a Hospital setting (this includes cognitive therapy and cardiac and pulmonary rehabilitation):
  - **Please note:** Speech therapy for very young children who have not yet started to speak is not considered restorative and, in most cases, is not covered under the Program;
- Ambulance services if Medically Necessary; and
• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment.

**Other Covered Services**

After you meet the annual Deductible, care and services are covered at 80% of the R&C Fees for the rest of that Calendar Year. Covered care and services include:

• Delivery care and services at a Hospital or a birthing center;

• Skilled nursing facility (up to a maximum of 100 days per Calendar Year);

• Home Health Care (up to a maximum of 100 days per Calendar Year):
  
  — The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available; and

  — The services and supplies included in the program of Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the program covers:

— Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

— Home health aid services;

— Physical, occupational or speech therapy by a qualified therapist;

— Dietary counseling;

— Medical social services;

— Medical supplies, drugs and medicines prescribed by a physician;

— Lab services (provided by or for a Home Health Care agency); and

— Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse or Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

— Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;

— Services that do not require the technical skills of a medical, Mental Health or dental professional;

— Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;

— Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;
— Transportation services;

— Services and supplies not Medically Necessary; and

— Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.

If a service provider furnishes a person both Home Health Care services and other services not covered under the program (such as Custodial Care), the program shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the program or non-covered services (such as Custodial Care);

• Hospice Care (Inpatient and Outpatient); covers terminal prognosis period up to 12 months; there are no day or dollar limits on this benefit;

• Infertility treatment (including coverage for pre-work to diagnose the cause of infertility and treatment to surgically correct the underlying medical cause of infertility; there is a $20,000 lifetime maximum):

— Prescription Drug expenses for infertility treatment do not apply to the infertility lifetime maximum. Rather, there is a separate pharmacy infertility benefit. See “Prescription Drug Benefits” beginning on page 158 for more information;

— Infertility procedures are covered if:

  − A female member is unable to conceive or produce conception after:

    • One year or more of timed, unprotected heterosexual sexual intercourse, if the female member is under age 35;

    • Six months of timed, unprotected heterosexual sexual intercourse, if the female member is over age 35; or

    • At least 12 cycles of donor insemination, for a female member without a male partner (six cycles for women age 35 or older);

    − The member’s medical records contain documentation stating there is a condition that is a demonstrated cause of infertility that has been recognized by a gynecologist, an infertility specialist and the physician who diagnosed the member as infertile;

    − The procedures are done while not confined in a Hospital or any other facility as an Inpatient;

    − The member has had a three day FSH test in the prior 12 months if under age 35 or in the prior six months if over age 35;

    − Day three FSH level of the female member is not greater than 19 mIU/mL in any (past or current) menstrual cycle;

    − The infertility is not caused by a hysterectomy or voluntary sterilization of either one of the partners (with or without surgical reversal); and

    − The member has attempted less costly medically appropriate treatment for which coverage is available under this Program;

• Durable medical equipment (for example, crutches, wheelchairs, braces);
• Inpatient and Outpatient facility and physician’s services for mouth, jaws and teeth (limited to
treatment to accidental injury of sound, natural teeth sustained while covered under the Retiree
Medical Program or for surgical removal of a tumor);

• Mental Health and Substance Use Disorder (for example, drug and alcohol) treatment in a
Residential Treatment Center, Partial Hospitalization Program or Intensive Outpatient Program; and

• Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco
product means a substance containing tobacco or nicotine, including cigarettes, cigars, smoking
tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes
services to aid in smoking cessation, including:
  — Preventive counseling visits (maximum of eight visits per 12 months);
  — Treatment visits; and
  — Class visits.

Some services routinely require determination by Cigna that the services are Medically Necessary.
Such services include, but are not limited to:

• Charges for court-ordered services, including those required as a condition of parole or release;

• Gender reassignment surgery that is Medically Necessary (coverage is subject to Precertification
and certain conditions; contact your carrier for details).

  For more information, check the Cigna schedule of benefits regarding gender reassignment surgery.
A schedule of benefits may be obtained by contacting Cigna directly. Coverage information is
available at no cost to any participant or beneficiary who requests it;

• Macromastia or gynecomastia surgeries;

• Abdominoplasty;

• Panniculectomy;

• Redundant skin surgery;

• Removal of skin tags;

• Craniosacral/cranial therapy;

• Prolotherapy;

• Transportation services;

• Inpatient and Outpatient facility and physician’s services for TMJ (limited benefit provided on a
case-by-case basis; excludes orthodontic treatment);

• Removal of an implant that alters the appearance of the body (such as breast or chin implants);

• Orthopedic footwear;

• Footwear to accommodate a diabetic condition;

• Surgical treatment of varicose veins;

• Acupuncture when it is performed by a physician or licensed practitioner as a form of anesthesia in
connection with surgery that is covered under the Retiree Medical Program option;

• Home uterine activity monitoring;
- Residential Treatment Centers; and
- Complementary and alternative medicine therapies (for example, biofeedback, bioenergetic therapy and hypnosis).

For a list of services not covered, see “Coverage Exclusions” beginning on page 172 for more information.

**In Case of Emergency**

If you have a medical Emergency, defined as an illness or injury that could cause serious bodily harm if not treated immediately, you should go to the nearest Hospital emergency room or urgent care facility. You do not have to call Cigna first to get Emergency care. Once you have the care you need, you should contact your personal physician to arrange for follow-up care.

If you are admitted to the Hospital, benefits are paid at 80% after you meet the annual Deductible (or paid at 70% of the R&C Fee after the annual Deductible in Hawaii only), as long as you call Cigna member services at 1-888-502-4462 within 48 hours of admission to the Hospital. (See “Precertification Rules” beginning on page 159 for more information.)

<table>
<thead>
<tr>
<th>Emergency Care Benefits At-A-Glance</th>
<th>Retiree Medical Program E – Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>Program pays 80% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Urgent care facility</td>
<td>Program pays 80% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for a true Emergency)</td>
<td>Program pays 80% of R&amp;C Fees after annual Deductible is met</td>
</tr>
<tr>
<td>Ambulance service (for routine or non-Emergency care)</td>
<td>Not covered*</td>
</tr>
</tbody>
</table>

*Ground ambulance support is covered if Medically Necessary, such as for transporting a patient from one Hospital to another. Contact Cigna for details.

**Prescription Drug Benefits**

If you enroll in Retiree Medical Program E – Indemnity, you will be enrolled automatically in the Retiree Prescription Drug Program administered by Express Scripts. You must purchase Prescription Drugs through the network of participating retail pharmacies or use the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar minimums and maximums as the table below illustrates.

<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Retiree Prescription Drug Program Administered by Express Scripts¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum and a $20.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
</tr>
</tbody>
</table>

Footnotes continue on page 159
1 The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

2 At a participating retail pharmacy, when the pharmacy’s Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table on page 158, you will pay the lower amount.

<table>
<thead>
<tr>
<th>Other Important Features</th>
<th>Prescription Drug Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fertility Drugs (Oral and Injectables)</td>
<td>$6,000 Maximum Lifetime Benefit (this limit is combined for retail and the Express Scripts Pharmacy home delivery prescriptions)</td>
</tr>
</tbody>
</table>

For more information about the Retiree Prescription Drug Program administered by Express Scripts, see “The Retiree Prescription Drug Program” beginning on page 31.

**Precertification Rules**

Precertification is an important tool in managing the quality and expense of Inpatient Hospital and facility admissions. You must call the toll-free number listed on your identification card to precertify Hospital admissions, as required by Retiree Medical Program E – Indemnity. (See also “In Case of Emergency” on page 158 for more information.) Failure to do so may affect your benefits. In an Emergency, seek care immediately, then call your physician within 48 hours for further assistance and directions on follow-up care.

**Precertification Rules At-A-Glance**

<table>
<thead>
<tr>
<th>Retiree Medical Program E – Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who should call</strong></td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td><strong>Where to call</strong></td>
</tr>
<tr>
<td>Cigna 1-888-502-4462</td>
</tr>
<tr>
<td><strong>When to call</strong></td>
</tr>
</tbody>
</table>
| Two weeks prior to scheduled admission (for Mental Health or Substance Use Disorder, before admission is scheduled to an Inpatient facility, Residential Treatment Center or a Partial Hospitalization Program)  
or  
Within 48 hours after Emergency admission (for Mental Health or Substance Use Disorder within 48 hours after admission to an Inpatient facility, a Residential Treatment Center or a Partial Hospitalization Program) |
| **If you call to precertify, and care is determined not Medically Necessary** |
| No coverage                                                              |
| **If you do not call to precertify, and care is Medically Necessary**    |
| 20% reduction in Eligible Expenses (If you reside in Hawaii: The Precertification penalty reduction cannot lower benefits paid to less than 70%, up to a maximum of $400 per Hospitalization, up to a maximum of $1,000 per Calendar Year) |
| **If you do not call to precertify, and care is not Medically Necessary** |
| No coverage                                                              |

If you are enrolled in Retiree Medical Program E – Indemnity, you must precertify Hospital and facility admissions, as well as Inpatient surgical procedures and diagnostic tests. Call Cigna member services at 1-888-502-4462 to precertify Hospital and facility admissions.
When you call, you will speak with an experienced consultant who will determine the medical necessity of your admission and length of stay, and can advise you of alternative options that may be appropriate.

**If you do not call to precertify, your Eligible Expenses will be reduced by 20% (if you reside in Hawaii, the Precertification penalty reduction cannot lower benefits paid to less than 70%, up to a maximum of $400 per Hospitalization, up to a maximum of $1,000 per Calendar Year).** If your admission, length of stay, Inpatient surgical procedure or test is not considered Medically Necessary by Cigna, no benefits will be paid.

You should call Cigna member services to determine whether your procedure requires Precertification.

**Filing Claims**

You must file a claim form for all Retiree Medical Program E – Indemnity care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses. You will receive your claim reimbursement following the receipt and approval of your completed form. You will find claim forms on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)), by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim.

If your claim is denied, you have the right to appeal the decision. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.) You can also contact Cigna for information on how to appeal a denied benefits claim.

**Centers of Excellence Program**

A “Centers of Excellence” Program provides access to medical facilities and staff who are experienced in specialty procedures like organ and tissue transplants, cardiac bypass surgery, angioplasty and brain/spinal cord injuries. The Program pays for Medically Necessary services and supplies involved with these procedures.

**Cigna LIFESOURCE Organ Transplant Network**

Cigna LIFESOURCE Organ Transplant Network is a network of nationally recognized medical centers that can provide the most appropriate care for members requiring organ or tissue transplants (including heart, heart/lung, lung, liver, kidney/pancreas and allogeneic bone marrow transplants). The Cigna LIFESOURCE Organ Transplant Network for Kids is also available to care for the special needs of children and their families. Retiree Medical Program E – Indemnity covers care and services at the 80% Coinsurance amount, after the annual Deductible.

Transportation and lodging benefits are covered for the patient and a companion when using a Cigna LIFESOURCE facility. Travel expenses are covered up to a maximum of $10,000 per transplant at a Cigna LIFESOURCE facility only.

**Cigna Healthy Rewards**

Through Cigna’s Healthy Rewards program, Cigna offers personalized services, online features and support to participants, including offering discounts on a variety of products and services. Access to Healthy Rewards is available regardless of which Cigna Retiree Medical Program option you enroll in. You can get more information regarding Healthy Rewards through the Cigna custom website for Prudential at [www.cigna.com/prudential](http://www.cigna.com/prudential) or by calling Cigna member services at 1-888-502-4462.
Medicare Advantage Programs

Medicare Advantage Programs, available to Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents, provide comprehensive medical coverage—including Prescription Drug benefits—that replaces the benefits provided under Medicare Part A (Hospital insurance), Part B (medical insurance) and Part D (Prescription Drug insurance). This approach differs from the traditional approach to Retiree medical coverage in which coverage is coordinated between two different medical programs—Medicare (Part A and Part B coverage) and Prudential Retiree Medical Program E – Indemnity coverage.

Generally, under a Medicare Advantage Program:

- You receive benefits only from the Medicare Advantage Program, not from a combination of traditional Medicare coverage and Prudential Retiree Medical Program E – Indemnity coverage; and

- You do not have to file a claim form if you receive services from a Participating Provider.

Medicare Advantage Programs receive funding from the Federal government and are highly regulated by the Centers for Medicare & Medicaid Services (CMS) and the State Insurance Department at the time the product is launched and thereafter. Regulation of Medicare Advantage Programs includes rates, benefits, service areas and materials.

Medicare Advantage Programs work similar to HMOs, with a network of Participating Providers. Generally, a participant must receive care from Providers in the network in order for those charges to be eligible for payment under the Medicare Advantage Program. Some Medicare Advantage Programs require participants to choose a Primary Care Physician (PCP), who provides basic routine care and makes referrals to Specialists within the network. Generally, benefits are paid only when care is provided by Participating Providers, Hospitals and pharmacies—except in the case of Emergency treatment. Your Prescription Drug benefits will be provided by the Medicare Advantage Program.

Where available, non-Medicare-eligible Qualified Dependents of Medicare-eligible participants may also be covered under “companion coverage” through the applicable Medicare Advantage Program carriers.

**Medicare Advantage Program Enrollment**

If you choose a Medicare Advantage Program, you are waiving traditional Medicare coverage. If you enroll in a Medicare Advantage Program:

- You must be enrolled in Medicare Part A and Part B (you must pay premiums for Medicare Part B); however, you do not need to enroll in Medicare Part D. **Please note:** Failure to pay Part B premiums (and Part D premiums, if applicable) will result in termination from your Medicare Advantage Program. See “Adjustments to Medicare Premiums” on page 186 for more information; and

- You must complete a separate Medicare Advantage Program enrollment form for each family member who is eligible for Medicare and enrolls in a Medicare Advantage Program.

**Please note:** A separate enrollment form needs to be completed for each family member who is eligible for Medicare and enrolls in a Medicare Advantage Program. This means that if you are covering a Spouse who is eligible for Medicare under the program, both you and your Spouse need to complete an enrollment form, and both forms should be returned to the Prudential Benefits Center. If an enrollment form is not completed for all Medicare-eligible family members, the entire family will default to Retiree Medical Program E – Indemnity. Please also note that if you are covering a Qualified Dependent who is not eligible for Medicare, that non-Medicare-eligible dependent should not complete an enrollment form.

**Medicare Advantage Program Enrollment During the Annual Enrollment Period**

If you first elect a Medicare Advantage Program or change Medicare Advantage Programs during the Annual Enrollment Period, you will need to complete an enrollment form and submit it to the
You are encouraged to submit your enrollment form as early as possible. If your form is received by the Prudential Benefits Center no later than the December deadline that will be noted in your Annual Enrollment materials, you will be enrolled in the Medicare Advantage Program effective the following January 1. Forms received after the December deadline cannot be guaranteed for an effective date of January 1, and may require you to remain enrolled in your current coverage or Retiree Medical Program E – Indemnity until January 31.

If you do not submit your enrollment form in a timely manner for an effective date of January 1, you can still submit your enrollment form in January, but your Medicare Advantage Program coverage will take effect on February 1 and you will be enrolled in your current coverage or Retiree Medical Program E – Indemnity for the month of January. If your enrollment form is not received by the Prudential Benefits Center by the end of January, you will not be enrolled in a new Medicare Advantage Program for that Calendar Year. Instead, you will remain enrolled in your current coverage or Retiree Medical Program E – Indemnity for the entire Calendar Year.

If you were covered under a Medicare Advantage Program and you elect Retiree Medical Program E – Indemnity, you will need to complete a disenrollment form to disenroll from the Medicare Advantage Program. When you disenroll from a Medicare Advantage Program, a disenrollment form will be mailed automatically to you. You need to complete this form and return it to the Prudential Benefits Center. If your form is received by the Prudential Benefits Center no later than the December deadline that will be noted in your Annual Enrollment materials, you will be enrolled in Retiree Medical Program E – Indemnity effective January 1. Forms received after the December deadline cannot be guaranteed for an effective date of January 1, and may require you to remain enrolled in your current coverage until January 31.

If you do not submit your disenrollment form in a timely manner for an effective date of January 1, you can still submit your completed disenrollment form in January, but your Retiree Medical Program E – Indemnity coverage will take effect on February 1 and you will be enrolled in your Medicare Advantage Program for the month of January. If your disenrollment form is not received by the Prudential Benefits Center by the end of January, you will not be enrolled in Retiree Medical Program E – Indemnity for that Calendar Year. Instead, you will remain enrolled in your current coverage for the entire Calendar Year.

If you are moving from one Medicare Advantage Program or the Medicare Cost Program to another Medicare Advantage Program or to the Medicare Cost Program, you do not need to submit a disenrollment form.

**Medicare Advantage Program Enrollment Outside of the Annual Enrollment Period**

If you enroll in a Medicare Advantage Program mid-year (for example, as a result of attaining Medicare eligibility mid-year, or experiencing a Qualified Change in Status or Retiring mid-year), an enrollment form will be mailed to your home address by the Prudential Benefits Center and a welcome kit may be mailed to your home address by the Medicare Advantage Program carrier. You must complete the enrollment form, including an effective date no earlier than the date you become eligible for Medicare. Then, you must sign and date the enrollment form and return it to the Prudential Benefits Center within 31 days on and following becoming eligible or within 31 days on and following the date of the Qualified Change in Status. Beginning on the date of the Qualified Change in Status, after you have made your elections and before the enrollment form is received and approved, you will be enrolled in Retiree Medical Program E – Indemnity (or your current coverage under a Medicare Advantage Program or Medicare Cost Program if you are changing your enrollment due to a Qualified Change in Status).

You are encouraged to submit your enrollment form as early as possible. If you do not return the form within 31 days on and following becoming eligible or within 31 days on and following the date of the Qualified Change in Status, you will default to Retiree Medical Program E – Indemnity and will remain covered under Retiree Medical Program E – Indemnity for the remainder of the Calendar Year. Participants who are enrolled in a Medicare Advantage Program or Medicare Cost Program at the time of a Qualified Change in Status and who do not return the form within 31 days on and following the date of the Qualified Change in Status will remain in their current Medicare Advantage Program or
Medicare Cost Program for the remainder of the Calendar Year, unless that coverage is no longer available, in which case, they will be enrolled in Retiree Medical Program E – Indemnity.

Please note: If you experience a Qualified Change in Status as a result of moving to a new permanent home address in which your current Medicare Advantage Program is not available, your enrollment in the Medicare Advantage Program will end automatically by the first day of the month following the date the Medicare Advantage Program carrier is notified of your Qualified Change in Status. You do not need to submit a disenrollment form. When your enrollment in the Medicare Advantage Program ends, you will be enrolled automatically in Retiree Medical Program E – Indemnity. If you wish to enroll in a new Medicare Advantage Program or Medicare Cost Program that provides service in your new location, you must complete an enrollment form and submit it to the Prudential Benefits Center within 31 days on and following the date of your Qualified Change in Status. If you do not return the form within 31 days on and following the date of your Qualified Change in Status, you will remain covered under Retiree Medical Program E – Indemnity for the remainder of the Calendar Year.

Please note that if you were covered under a Medicare Advantage Program and you elect Retiree Medical Program E – Indemnity during the Annual Enrollment Period or as a result of a Qualified Change in Status, you will need to complete a separate form to disenroll from the Medicare Advantage Program. When you change your Retiree Medical Program elections, a disenrollment form will be mailed to you. If you need a disenrollment form, contact the Prudential Benefits Center.

If you are moving from one Medicare Advantage Program or the Medicare Cost Program to another Medicare Advantage Program or to the Medicare Cost Program, you do not need to submit a disenrollment form. However, you will be required to complete an enrollment form for your newly elected Medicare Advantage Program or Medicare Cost Program. If you are adding a new Medicare-eligible Dependent to your newly elected coverage, you need to submit an enrollment form for that Medicare-eligible Dependent, and that Dependent must complete his/her own paperwork, with signature. (The Retiree cannot sign the forms on behalf of his/her Dependents.)

Prescription Drug Benefits

If you enroll in a Medicare Advantage Program, you do not have access to the Retiree Prescription Drug Program administered by Express Scripts. Instead, your Prescription Drug benefits will be provided through the Medicare Advantage Program. However, if you enroll in an Aetna or UHC Medicare Advantage Program and cover a non-Medicare-eligible Qualified Dependent, the Prescription Drug benefits for your Qualified Dependent will be provided by the Retiree Prescription Drug Program.

Please note: The Medicare Advantage Programs exclude coverage for any medications that are excluded from coverage under Medicare Part D. For more information about coverage under a Medicare Advantage Program, contact the Medicare Advantage Program carrier or refer to the Evidence of Coverage you received from your Medicare Advantage Program carrier.

Companion Coverage

Medicare Advantage Programs are available only to participants who are eligible for Medicare. Some Medicare Advantage Program carriers have a corresponding “companion” coverage option available for non-Medicare-eligible Qualified Dependents of Medicare-eligible participants. For those programs that offer companion coverage, participants who are eligible for Medicare may enroll themselves in the Medicare Advantage Program and their non-Medicare-eligible Qualified Dependents in the corresponding companion coverage option. For example, if you enroll in one of the Aetna Medicare Advantage Programs, you may enroll your non-Medicare-eligible Spouse in Aetna's Companion Coverage. The benefit design features (for example, Copays) for companion coverage may differ from the design features of the Medicare Advantage Program. Please see the Annual Enrollment materials or contact the Medicare Advantage Program carrier for a complete description of benefit design features.
Please note: If you elect coverage through an Aetna or UHC Medicare Advantage Program and cover a non-Medicare-eligible Qualified Dependent under companion coverage, the Prescription Drug benefits for your non-Medicare-eligible Qualified Dependent will be provided by the Retiree Prescription Drug Program, not the companion coverage.

Additional information about the companion coverage that may be available through the applicable Medicare Advantage Programs is included in this SPD booklet. See the “Companion Coverage” section beginning on page 168.
**Medicare Cost Program**

The Medicare Cost Program, available to Medicare-eligible Retirees, Long Term Disability participants and Surviving Dependents, provides comprehensive medical coverage—including Prescription Drug benefits—that replaces the benefits provided under Medicare Part A (Hospital insurance), Part B (medical insurance) and Part D (Prescription Drug insurance). To be eligible for the Medicare Cost Program, you must be eligible for Medicare, enrolled in Medicare Part A and enrolled in and paying premiums for Medicare Part B.

The HealthPartners Medicare Cost HMO is offered to Medicare-eligible participants in Minnesota and select counties in Wisconsin.

When you enroll in the Medicare Cost Program, you will still retain your Medicare benefits. Medicare is primary on any Part A services (the provider submits claims to Medicare), and your new Medicare Cost Program is primary on Part B services (the provider submits claims to the Medicare Cost Program). Your Prescription Drug benefits will be provided by the Medicare Cost Program.

With the Medicare Cost Program, you pay a monthly contribution (if applicable) and the program provides you with comprehensive medical coverage. You continue to pay premiums for Medicare Part B; however, you do not need to pay a separate Medicare Part D premium.

Medicare Cost Programs receive funding from the Federal government. Similar to Medicare Advantage Programs, Medicare Cost Programs are highly regulated by the Centers for Medicare & Medicaid Services (CMS) and the State Insurance Department at the time the product is launched and thereafter. Regulation of Medicare Cost Programs includes rates, benefits, service areas and materials.

If you enroll in the HealthPartners Medicare Cost HMO, Out-of-Network coverage may only be available in Emergency or urgent care situations. Participants are able to use the extended absence benefit while traveling and do not need a referral when seeing a Specialist. Please contact HealthPartners for further details.

If you are eligible for Medicare and the Medicare Cost Program is available in the area in which you reside, you should compare the benefits it offers and your Cost for coverage against other Retiree Medical Program options available to you.

Non-Medicare-eligible Qualified Dependents of Medicare-eligible participants may also be covered under “companion coverage” through HealthPartners.

**Medicare Cost Program Enrollment**

If you choose the Medicare Cost Program, you retain your traditional Medicare coverage. If you enroll in the Medicare Cost Program:

- You must enroll in Medicare Part A and Part B (you must pay premiums for Medicare Part B); however, you do not need to enroll in Medicare Part D. **Please note:** Failure to pay Part B premiums (and Part D premiums, if applicable), will result in termination from your Medicare Cost Program. See “Adjustments to Medicare Premiums” on page 186 for more information; and

- You must complete a separate Medicare Cost Program enrollment form for each family member who is eligible for Medicare and enrolls in the Medicare Cost Program.

**Please note:** A separate enrollment form needs to be completed for each family member who is eligible for Medicare and enrolls in the Medicare Cost Program. This means that if you are covering a Spouse who is eligible for Medicare under the program, both you and your Spouse need to complete an enrollment form, and both forms should be returned to the Prudential Benefits Center. If an enrollment form is not completed for all Medicare-eligible family members, the entire family will default to Retiree Medical Program E – Indemnity. Please also note that if you are covering a Qualified Dependent who is not eligible for Medicare, that non-Medicare-eligible dependent should not complete an enrollment form.
Medicare Cost Program Enrollment During the Annual Enrollment Period

If you first elect the Medicare Cost Program during the Annual Enrollment Period, you will need to complete an enrollment form and submit it to the Prudential Benefits Center. You are encouraged to submit your enrollment form as early as possible. If your form is received by the Prudential Benefits Center no later than the December deadline that will be noted in your Annual Enrollment materials, you will be enrolled in the Medicare Cost Program effective the following January 1. Forms received after the December deadline cannot be guaranteed for an effective date of January 1, and may require you to remain enrolled in your current coverage or Retiree Medical Program E – Indemnity until January 31.

If you do not submit your enrollment form in a timely manner for an effective date of January 1, you can still submit your enrollment form in January, but your Medicare Cost Program coverage will take effect on February 1 and you will be enrolled in your current coverage or Retiree Medical Program E – Indemnity for the month of January. If your enrollment form is not received by the Prudential Benefits Center by the end of January, you will not be enrolled in the Medicare Cost Program for that Calendar Year. Instead, you will remain enrolled in your current coverage or Retiree Medical Program E – Indemnity for the entire Calendar Year.

If you were covered under the Medicare Cost Program and you elect Retiree Medical Program E – Indemnity, you will need to complete a disenrollment form to disenroll from the Medicare Cost Program. When you disenroll from the Medicare Cost Program, a disenrollment form will be mailed automatically to you. You need to complete this form and return it to the Prudential Benefits Center. If your form is received by the Prudential Benefits Center no later than the December deadline that will be noted in your Annual Enrollment materials, you will be enrolled in Retiree Medical Program E – Indemnity effective January 1. Forms received after the December deadline cannot be guaranteed for an effective date of January 1, and may require you to remain enrolled in your current coverage until January 31.

If you do not submit your disenrollment form in a timely manner for an effective date of January 1, you can still submit your completed disenrollment form in January, but your Retiree Medical Program E – Indemnity coverage will take effect on February 1 and you will be enrolled in your Medicare Cost Program for the month of January. If your disenrollment form is not received by the Prudential Benefits Center by the end of January, you will not be enrolled in Retiree Medical Program E – Indemnity for that Calendar Year. Instead, you will remain enrolled in your current coverage for the entire Calendar Year.

If you are moving from one Medicare Advantage Program or the Medicare Cost Program to another Medicare Advantage Program or to the Medicare Cost Program, you do not need to submit a disenrollment form.

Medicare Cost Program Enrollment Outside of the Annual Enrollment Period

If you enroll in the Medicare Cost Program mid-year (for example, as a result of attaining Medicare eligibility mid-year, or experiencing a Qualified Change in Status or Retiring mid-year), an enrollment form will be mailed to your home address by the Prudential Benefits Center and a welcome kit may be mailed to your home address by HealthPartners. You must complete the enrollment form, including an effective date not earlier than the date you become eligible for Medicare. Then, you must sign and date the enrollment form and return it to the Prudential Benefits Center within 31 days on and following becoming eligible or within 31 days on and following the date of the Qualified Change in Status. Beginning on the date of the Qualified Change in Status, after you have made your elections and before the enrollment form is received and approved, you will be enrolled in Retiree Medical Program E – Indemnity (or your current coverage under a Medicare Advantage Program or Medicare Cost Program if you are changing your enrollment due to a Qualified Change in Status).

You are encouraged to submit your enrollment form as early as possible. If you do not return the form within 31 days on and following becoming eligible or within 31 days on and following the date of the Qualified Change in Status, you will default to Retiree Medical Program E – Indemnity and will remain covered under Retiree Medical Program E – Indemnity for the remainder of the Calendar Year. Participants who are enrolled in a Medicare Advantage Program or the Medicare Cost Program at the
time of a Qualified Change in Status and who do not return the form within 31 days on and following
the date of the Qualified Change in Status will remain in their current Medicare Advantage Program or
Medicare Cost Program for the remainder of the Calendar Year, unless that coverage is no longer
available, in which case, they will be enrolled in Retiree Medical Program E – Indemnity.

Please note: If you experience a Qualified Change in Status as a result of moving to a new permanent home
address in which your Medicare Cost Program is not available, your enrollment in the Medicare Cost Program
will end automatically by the first day of the month following the date HealthPartners is notified of your
Qualified Change in Status. You do not need to submit a disenrollment form. When your enrollment in the
Medicare Cost Program ends, you will be enrolled automatically in Retiree Medical Program E – Indemnity. If
you wish to enroll in a new Medicare Advantage Program that provides service in your new location, you must
complete an enrollment form and submit it to the Prudential Benefits Center within 31 days on and following
the date of your Qualified Change in Status. If you do not return the form within 31 days on and following the
date of your Qualified Change in Status, you will remain covered under Retiree Medical Program E – Indemnity
for the remainder of the Calendar Year.

Please note that if you were covered under the Medicare Cost Program and you elect Retiree Medical
Program E – Indemnity during the Annual Enrollment Period or as a result of a Qualified Change in
Status, you will need to complete a separate form to disenroll from the Medicare Cost Program. When
you change your Retiree Medical Program elections, a disenrollment form will be mailed to you. If you
need a disenrollment form, contact the Prudential Benefits Center.

If you are moving from one Medicare Advantage Program or the Medicare Cost Program to another
Medicare Advantage Program or to the Medicare Cost Program, you do not need to submit a
disenrollment form. However, you will be required to complete an enrollment form for your newly
elected Medicare Advantage Program or Medicare Cost Program. If you are adding a new
Medicare-eligible Dependent to your newly elected coverage, you need to submit an enrollment form
for that Medicare-eligible Dependent and that Dependent must complete his/her own paperwork, with
signature. (The Retiree cannot sign the forms on behalf of his/her Dependents.)

Prescription Drug Benefits

If you enroll in the Medicare Cost Program, you do not have access to the Retiree Prescription Drug
Program administered by Express Scripts. Instead, your Prescription Drug benefits will be provided
through the Medicare Cost Program.

Please note: The Medicare Cost Program excludes coverage for any medications that are excluded from
coverage under Medicare Part D. For more information about coverage under the Medicare Cost Program,
contact HealthPartners or refer to the Evidence of Coverage you received from HealthPartners.

Companion Coverage

The Medicare Cost Program is available only to participants who are eligible for Medicare.
HealthPartners also offers “companion” coverage for non-Medicare-eligible Qualified Dependents of
Medicare-eligible participants. Participants who are eligible for Medicare may enroll themselves in the
Medicare Cost Program and their non-Medicare-eligible Qualified Dependents will be enrolled
automatically for companion coverage. For example, if you enroll in the Medicare Cost Program and
you also enroll your non-Medicare-eligible Spouse for medical coverage, your Spouse will be enrolled
in companion coverage automatically. The benefit design features (for example, Copays) for
companion coverage may differ from the design features of the Medicare Cost Program. See the
“Companion Coverage” section beginning on page 168 for more information. Please check with
HealthPartners for a complete description of benefit design features.
Companion Coverage

Availability of Companion Coverage

Some Medicare Advantage Programs and the Medicare Cost Program offer “companion” coverage for Medicare-eligible participants covering Qualified Dependents who are not yet eligible for Medicare. For those programs that offer companion coverage, Medicare-eligible participants may enroll in the Medicare Advantage Program or Medicare Cost Program and their Qualified Dependents who are not yet eligible for Medicare will be enrolled automatically in companion coverage.

Eligibility

Your Qualified Dependent is eligible to enroll in the program if he/she is a non-Medicare-eligible Qualified Dependent of a Retiree, a Long Term Disability participant or a surviving Spouse who is enrolled in a Medicare Advantage Program or the Medicare Cost Program. The companion coverage that may be available is based on the Medicare Advantage Program or Medicare Cost Program that the Retiree, Long Term Disability participant or surviving Spouse is enrolled in, as outlined in the following table. Please note that some Medicare Advantage Programs do not offer companion coverage.

<table>
<thead>
<tr>
<th>Medicare Advantage Program or Medicare Cost Program</th>
<th>Companion Coverage Available</th>
<th>Companion Coverage Offers Same Medical Benefits as Non-Medicare-Eligible HMO</th>
<th>Retiree Prescription Drug Coverage for Companion Coverage and Non-Medicare-Eligible HMO Provided by:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aetna</td>
<td>Yes</td>
<td>Yes</td>
<td>Express Scripts</td>
</tr>
<tr>
<td>Health Plan Nevada (Program terminated effective December 31, 2013)</td>
<td>No</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>HealthPartners</td>
<td>Yes</td>
<td>Yes</td>
<td>HealthPartners</td>
</tr>
<tr>
<td>Humana</td>
<td>Yes</td>
<td>Not applicable*</td>
<td>Humana</td>
</tr>
<tr>
<td>MVP Health Care</td>
<td>No</td>
<td>Not applicable</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Tufts</td>
<td>Yes</td>
<td>Yes</td>
<td>Tufts</td>
</tr>
<tr>
<td>UHC</td>
<td>Yes</td>
<td>Not applicable*</td>
<td>Express Scripts</td>
</tr>
</tbody>
</table>

* A Prudential-sponsored HMO program from this carrier is not available to non-Medicare-eligible Retirees.

If you are a Retiree, Long Term Disability participant or surviving Spouse and you have coverage under a Medicare Advantage Program that does not offer companion coverage, you may either:

- Select another Medicare Advantage Program or Medicare Cost Program with companion coverage, if available in your area;
- Enroll yourself in the Medicare Advantage Program or Medicare Cost Program and choose no Qualified Dependent coverage; or
- Choose not to enroll in the Medicare Advantage Program and, instead, enroll in Retiree Medical Program E – Indemnity, in which case you may also enroll Qualified Dependents who are not eligible for Medicare.

Please note: You can only make a change to your coverage during the Annual Enrollment Period or if you experience a Qualified Change in Status during the Calendar Year. Unlike the Medicare Advantage
Programs and the Medicare Cost Program, there are no special enrollment or disenrollment forms required for companion coverage.

**How the Program Works**

**Network and Non-Network Benefits**

As a participant in this Program, you are required to obtain services from a network physician or other health care professional, but have the freedom to choose the network physician or other health care professional you prefer each time you need to receive Covered Services. Depending on the program, when you enroll you may need to select a Primary Care Physician (PCP) who will coordinate your care and you may need PCP referrals for Specialist care.

You are eligible for benefits under this Program when you receive Covered Services from physicians and other health care professionals who have contracted with the carrier for the companion coverage to provide those services. Except as specifically described within this SPD booklet, benefits are not available for services provided by a non-Participating Provider.

**Participating Providers**

The carrier for the companion coverage or its affiliates arrange for health care Providers to participate in a network. Provider listings under each health care carrier are available separately from this SPD booklet. Provider information is available at no cost to you. If you need provider information, several sources are available:

- You will find links to many of the carriers’ websites on the Prudential Benefits Center website (at www.prubenefitscenter.com);

- Refer to the Annual Enrollment materials provided during the Annual Enrollment Period for information on how to contact your carrier directly through their website or their member services telephone number;

- To have provider information mailed to you at no cost, you can call the carrier’s member services telephone number; or

- Call the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and follow the prompts for Health and Welfare benefits.

**Looking for a Network Provider?**

The network of health care providers for companion coverage is different from the network of health care providers for the corresponding Medicare Advantage Program or Medicare Cost Program. To find a list of Participating Providers, call your carrier or visit its website for a directory of health care professionals and facilities in the carrier’s network.

**Program Highlights**

For companion coverage through Aetna or UnitedHealthcare, the table on the following page provides an overview of Copays, Coinsurance and Deductibles that apply when you receive certain Covered Services, and outlines the Program’s Annual Out-of-Pocket Maximum. If you enroll in an Aetna Medicare Advantage Program and wish to cover your non-Medicare-eligible Qualified Dependents, they will receive companion coverage through the Aetna HMO. If you enroll in a UHC Medicare Advantage Program and wish to cover your non-Medicare-eligible Qualified Dependents, they will receive companion coverage through the UHC Companion Program. In general, the UHC Companion Program benefit details are substantially similar to the Aetna HMO benefits. For specific program details, please refer to the “Health Maintenance Organizations” section of this SPD booklet, beginning on page 131. Please note that the specific benefits through other companion coverage carriers will vary. You should contact your carrier for information about program details.
**Aetna and UHC Companion Coverage At-A-Glance**

<table>
<thead>
<tr>
<th>Category</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Deductible¹</td>
<td>$200 per individual, $400 per family</td>
</tr>
<tr>
<td>Annual Out-of-Pocket Maximum¹ (Includes annual Deductible. For the 2013 Plan Year, excludes Hospital and emergency room Copays. For the 2014 Plan Year, includes Hospital and emergency room Copays.)</td>
<td>$1,400 per individual, $2,800 per family</td>
</tr>
<tr>
<td>Preventive Care²</td>
<td>Program pays 100%, no annual Deductible</td>
</tr>
<tr>
<td>Primary Care and Specialty Care Office Visits</td>
<td>Program pays 90% after annual Deductible is met</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>Program pays 90% after annual Deductible is met</td>
</tr>
<tr>
<td>Hospital Stays</td>
<td>Program pays 90% after annual Deductible is met and $150 Hospital Copay per admission</td>
</tr>
<tr>
<td>Mental Health and Substance Use Disorder Services</td>
<td>• Inpatient services: Program pays 90% after annual Deductible is met and $150 Hospital Copay per admission</td>
</tr>
<tr>
<td></td>
<td>• Outpatient services: Program pays 90% after annual Deductible is met</td>
</tr>
</tbody>
</table>

¹ Prescription Drug charges do not apply toward the annual Deductible or the Annual Out-of-Pocket Maximum under the Aetna or UHC Companion Coverage. In addition, for claims incurred during the 2013 Plan Year, Hospital and emergency room Copays did not apply against the Annual Out-of-Pocket Maximum. For the 2014 Plan Year, Hospital and emergency room Copays apply toward the Annual Out-of-Pocket Maximum. Some services have specific limits or restrictions; see individual service for more information. Certain services are not covered.

² Preventive Care benefits are subject to applicable age and frequency limits. Please contact the carrier for details.

**Prescription Drug Benefits**

If your non-Medicare-eligible Qualified Dependent participates in the companion coverage provided through Aetna or UnitedHealthcare, he/she will be enrolled automatically in the Retiree Prescription Drug Program administered by Express Scripts. Your Qualified Dependent must purchase Prescription Drugs through the network of participating retail pharmacies or use the Express Scripts Pharmacy home delivery service, or you will be responsible for the full cost, except in the event of an Emergency.

Participants in other companion coverage programs are not eligible for the Retiree Prescription Drug Program administered by Express Scripts. Instead, Prescription Drug coverage is provided directly through the companion coverage carrier. These programs may have benefits that differ from what is described in this section. Please contact your carrier directly for details.

Through the Retiree Prescription Drug Program administered by Express Scripts, your share of Prescription Drug costs is called Coinsurance, a percentage of the total cost, subject to dollar minimums and maximums, as the table on page 171 illustrates.
<table>
<thead>
<tr>
<th>Prescription Drugs</th>
<th>Generic</th>
<th>Brand-Name Preferred</th>
<th>Brand-Name Non-Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Participating Retail Pharmacies (up to a 30-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $5.00 minimum and a $20.00 maximum</td>
<td>You pay 25% Coinsurance, subject to a $25.00 minimum and a $45.00 maximum</td>
<td>You pay 40% Coinsurance, subject to a $40.00 minimum and a $100.00 maximum</td>
</tr>
<tr>
<td>Through the Express Scripts Pharmacy (home delivery) (up to a 90-day supply)</td>
<td>You pay 25% Coinsurance, subject to a $10.00 minimum and a $40.00 maximum</td>
<td>You pay 25% Coinsurance, subject to a $50.00 minimum and a $90.00 maximum</td>
<td>You pay 40% Coinsurance, subject to an $80.00 minimum and a $200.00 maximum</td>
</tr>
</tbody>
</table>

The Retiree Prescription Drug Program covers certain preventive medications at 100%. To receive these medications covered at 100%, you must have an authorized prescription from your doctor and the medications must be dispensed by a participating retail pharmacy or the Express Scripts Pharmacy (home delivery). For more information, see “Preventive Medications” beginning on page 34.

At a participating retail pharmacy, when the pharmacy's Usual and Prevailing Charge is lower than the minimum Coinsurance amounts shown in the table above, you will pay the lower amount.

For more information about the Retiree Prescription Drug Program administered by Express Scripts, see “The Retiree Prescription Drug Program” section beginning on page 31.

For information about the Prescription Drug benefits under other companion coverage programs, contact the carrier directly by calling the telephone number on your identification card.
Common Features for All Retiree Medical Programs

Coverage Exclusions

Some charges are not covered by any portion of Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO or Retiree Medical Program E – Indemnity, or the companion coverage under the Aetna and, in general, UHC Medicare Advantage Programs. For exclusions under a local HMO, Medicare Advantage Program or Medicare Cost Program, contact the HMO, Medicare Advantage Program or Medicare Cost Program directly. For exclusions under the Retiree Prescription Drug Program, see “Prescription Drug Expenses Not Covered” on page 39. For Prescription Drug exclusions under the HDHP, see “Prescription Drug Expenses NotCovered” on page 69.

These items include, but are not limited to:

- Charges for services that do not require the technical skills of a medical, a Mental Health or a dental professional;

- Charges submitted for services by an unlicensed Hospital, facility, physician or other provider or not within the scope of the provider’s license;

- Charges for services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is part of his/her family, any health care provider or any health care facility;

- Charges for services furnished solely because the person is an Inpatient on any day on which the person’s disease or injury could safely and adequately be diagnosed or treated while not confined;

- Charges for services furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician’s or a dentist’s office or other less costly setting;

- Charges in connection with any injury sustained in the course of (or arising as a result of) any work for wage or profit, whether or not for Prudential; or due to any disease covered by any Workers’ Compensation law, occupational disease law or similar law with respect to such work;

- Charges furnished by or for any government unless payment of the charge is required by law;

- Charges for services or supplies that are provided by any law or governmental program (except for a state program under Medicaid or similar law that is intended to pay benefits in excess of private insurance) under which the patient is or could be covered;

- Charges for services and supplies not necessary, as determined by the medical carrier, for the diagnosis, care or treatment of the disease or injury involved. This applies even if the services are prescribed, recommended or approved by the attending physician or dentist;

- Charges for Experimental or Investigational services or supplies as determined by the carrier based on commonly accepted medical guidelines (complications that arise from a non-Medically Necessary or experimental procedure are covered);

- Charges for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment;

- Charges for blood or blood plasma that is replaced by or for the patient except for autologous donation in anticipation of scheduled services where in the health plan medical director’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery;

- Charges for dental services, unless the charge is for:
  
  — The treatment or removal of a tumor; or
— The treatment of natural teeth due to accidental injury within the 12-month period following the accident and the charges are for a doctor’s services, x-rays or exams;

• Charges for care or treatment to the teeth, gums or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak;

• Charges for routine foot care;

• Eye care charges to determine the need for glasses or corrective vision (eyeglasses and contact lenses are also excluded, except for the first pair of contact lenses or eyeglasses, including lenses and frames, for treatment of keratoconus or post-cataract surgery).

The Program also does not cover:
— Vision service or supply that does not meet professionally accepted standards;
— Eye exams during your stay in a Hospital or other facility for health care;
— Eye exams for contact lenses or their fitting;
— Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
— Replacement of lenses or frames that are lost or stolen or broken;
— Acuity tests; or
— Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;

• Charges for or related to any eye surgery mainly to correct refractive errors;

• Charges for cosmetic or reconstructive surgery, any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
  — Face lifts, body lifts, tummy tucks, liposuctions, removal or reduction of non-malignant moles, blemishes, cosmetic eyelid surgery and other surgical procedures;
  — Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
  — Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
  — Insertion of any implant that alters the appearance of the body (such as breast or chin implants);
  — Removal of tattoos (except for tattoos applied to assist in covered medical treatments, such as markers for radiation therapy);
  — Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
  — Breast augmentation; or
  — Otoplasty.

Unless the cosmetic surgery charges are for:
— Corrective treatment for an accidental injury (surgery must be performed in the Calendar Year of the accident which causes the injury or in the next Calendar Year);

— Surgery to treat a condition, including a birth defect, that impairs the function of a body organ; or

— Surgery to reconstruct a breast after a mastectomy performed to treat a disease;

• Hearing exams and hearing aids;

• Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;

• Maintenance Care, which is care that serves to prevent an existing condition from getting worse rather than to actively treat the condition;

• Comfort and convenience items and services including, but not limited to, such items as TVs, telephones, first-aid kits, purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, humidifiers, water purifiers, waterbeds, swimming pools, saunas and hot tubs;

• Charges for wigs or other hair replacement supplies;

• Charges for services or supplies provided by Prudential or by a close relative;

• Charges for which the covered person is not legally required to pay;

• Charges for medical transportation except for Emergency transportation to the nearest facility that can provide appropriate care and Medically Necessary transfers by ambulance;

• Charges for the reversal of sterilization;

• Career, pastoral or financial counseling;

• Charges for the following mental disorders:
  — Neurodevelopmental disorders, including intellectual disabilities, communication disorders, specific learning disorder and motor disorders;
  — Neurocognitive disorders, including delirium, mild and major neurocognitive disorders; and
  — Sexual dysfunctions;

• Services or supplies furnished by a Participating Provider that are in excess of that provider’s Negotiated Rate for the service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of this Program are paid;

• Charges for consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to, bandages and other disposable medical supplies, skin preparations and test strips, except when specified as covered;

• Charges for care furnished mainly to provide a surrounding free from exposure that can worsen the person’s disease or injury, including:
  — Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, including:
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices;
- Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, waterbeds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness; and
- Structural modifications of a personal residence to accommodate a disability;

- Charges for services of a resident physician or intern rendered in that capacity;
- Charges for performance, athletic performance or lifestyle enhancement drugs or supplies;
- Charges for acupuncture, acupressure and acupuncture therapy;
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs. Additional smoking exclusions and weight loss exclusions include:
  - Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum (except as described under “Covered Services” beginning on page 46 for Retiree Medical Program E – HDHP, page 85 for Retiree Medical Program E – CDHP 80, page 112 for Retiree Medical Program E – CDHP 90, page 135 for the Aetna HMO and page 152 for Retiree Medical Program E – Indemnity);
  - Please note: The Retiree Prescription Drug Program and the HDHP provide coverage for eligible smoking cessation products (as provided in the “Covered Prescription Drugs” sections beginning on pages 33 and 63 of this SPD booklet); and
  - Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions; except as provided by this SPD booklet, including but not limited to:
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs or other forms of activity or activity enhancement;

- Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this SPD booklet;
- Any non-Emergency charges incurred outside of the United States if:
  - You traveled to such location to obtain supplies even if otherwise covered under this SPD booklet;
— Such supplies are unavailable or illegal in the United States; or
— The purchase of such supplies outside the United States is considered illegal;

• Charges for any device intended to perform the function of a body organ, and which is determined by the Claims Administrator to be Experimental or Investigational, not Medically Necessary or cosmetic in nature;

• Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the Program;

• Charges for any services or supplies related to education, training or retraining services, including, for example: testing, special education, remedial education, job training and job hardening programs;

• Charges for any health examinations:
  — Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  — Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
  — Required to attend a camp or sporting event or participate in a sport or other recreational activity; and
  — Any special medical reports not directly related to treatment except when provided as part of a covered service;

• Facility charges for care services or supplies provided in:
  — Rest homes;
  — Assisted living facilities;
  — Similar institutions serving as an individual’s primary residence or providing primarily custodial or rest care;
  — Health resorts;
  — Spas, sanitariums; or
  — Infirmaries at schools, colleges or camps;

• Charges for any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except infant formula when infant formula is needed for the treatment of inborn errors of metabolism;

• Charges for any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth;

• Charges for any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries;

• Charges for infertility services (except as provided in this SPD booklet), including:
  — Purchase of donor sperm;
— Care of donor egg retrievals or donor costs;
— Cryopreservation or storage of cryopreserved embryos or sperm, including thawing;
— Home ovulation predictor kits; and
— Gestational carrier programs for the non-member carrier;

• Miscellaneous charges for services or supplies including:
  — Annual or other charges to be in a physician’s practice;
  — Cancelled or missed appointment charges or charges to complete claim forms; and
  — Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    – Care in charitable institutions;
    – Care for conditions related to current or previous military service;
    – Care while in the custody of a governmental authority;
    – Any care a public Hospital or other facility is required to provide; or
    – Any care in a Hospital or other facility owned or operated by any Federal, state or other governmental entity, except to the extent coverage is required by applicable laws;

• Charges for nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities);

• Charges for private duty nursing during your stay in a Hospital, and Outpatient private duty nursing services except as specifically described under “Covered Services” beginning on page 46 for Retiree Medical Program E – HDHP, page 85 for Retiree Medical Program E – CDHP 80, page 112 for Retiree Medical Program E – CDHP 90, page 135 for the Aetna HMO and page 152 for Retiree Medical Program E – Indemnity;

• Charges for services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued (see “Continuing Your Coverage” beginning on page 207);

• Services that are not covered under this SPD booklet;

• Services and supplies provided in connection with treatment or care that is not covered under the Program;

• Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided under “Covered Services” beginning on page 46 for Retiree Medical Program E – HDHP, page 85 for Retiree Medical Program E – CDHP 80, page 112 for Retiree Medical Program E – CDHP 90, page 135 for the Aetna HMO and page 152 for Retiree Medical Program E – Indemnity;

• Any of the following treatments or procedures:
  — Aromatherapy;
  — Carbon dioxide therapy;
— Chelation therapy (except for heavy metal poisoning);
— Computer-aided tomography (CAT) scanning of the entire body;
— Gastric irrigation;
— Hair analysis;
— Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
— Intensive intervention programs for autism spectrum disorder (for example, Lovaas therapy, applied behavior analysis or early intensive behavior intervention);
— Massage therapy;
— Megavitamin therapy;
— Primal therapy;
— Psychodrama;
— Purging;
— Rolfing;
— Sensory or auditory integration therapy; and
— Thermograms and thermography;

• Transplant coverage does not include charges for:
  — Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an Outpatient transplant occurrence;
  — Services and supplies furnished to a donor when recipient is not a covered person;
  — Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing illness;
  — Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness; and
  — Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise precertified;

• Any illness or injury related to employment or self-employment including any illness or injury that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers’ compensation, or an occupational illness or similar program under local, state or Federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers’ compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered “non-occupational” regardless of cause; and

• Charges for the following services, even as they relate to gender reassignment surgery and are considered cosmetic: Abdominoplasty; blepharoplasty; breast enlargement procedures including augmentation mammoplasty, implants and silicone injections of the breast; collagen injections;
electrolysis; hair removal/hair transplantation; testicular expanders; jaw shortening/sculpturing/facial bone reduction; mastopexy; neck tightening; nipple/areola reconstruction; removal of redundant skin; replacement of tissue expander with permanent prosthesis testicular insertion; rhinoplasty; second stage phalloplasty; surgical correction of hydraulic abnormality of inflatable (multi-component) prosthesis including pump and/or cylinders and/or reservoir; trachea shave/reduction thyroid chondroplasty; voice modification surgery; voice therapy/voice lessons; forehead, brow or face-lifting; lip enhancement or reduction; facial bone reduction; liposuction; laryngoplasty or shortening of the vocal cords, which have been used in feminization; and cheek implants, chin implants, nose implants and lip reduction, which have been used to assist masculinization.

This list is not all-inclusive. Contact your carrier for more information about services not covered.

In addition to the exclusions listed for the Programs above, the following additional exclusion applies to Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO, Retiree Medical Program E – Indemnity and companion coverage under the Aetna and UHC Medicare Advantage Programs: Charges for Prescription Drugs other than those administered in a Hospital are not covered under these Retiree Medical Program options. Such charges are instead covered under the Retiree Prescription Drug Program administered by Express Scripts.

The following additional exclusions apply to the Aetna HMO and companion coverage under the Aetna Medicare Advantage Program:

- Charges for specific non-standard allergy services and supplies, including but not limited to, skin titration (wrinkle method), cytotoxicity testing (Bryan’s Test), treatment of non-specific candida sensitivity and urine autoinjections;
- Transplant services and supplies not obtained from an Institute of Excellence, including the harvesting of organs, bone marrow, tissue or stem cells for storage purposes;
- Charges for home infusion therapy after a transplant occurrence, unless rendered in accordance with the follow-up period outlined in the transplant facility’s contract;
- Infertility services and supplies furnished by a non-Participating Provider or as excluded as shown under “Other Covered Services” beginning on page 138;
- Services that are not covered under this SPD booklet, even when a prior referral has been issued by a PCP; and
- Wilderness therapy programs, boot camps (also known as behavior modification facilities), military schools and specialty schools (such as those for children with autism spectrum disorder).

The following additional exclusions apply to Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90 and Retiree Medical Program E – Indemnity:

- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Dance therapy;
- Movement therapy;
- Applied kinesiology;
- Extracorporeal shock waves lithotripsy (ESWL) for musculoskeletal and orthopedic conditions;
- Infertility services and supplies excluded as shown under “Other Covered Services” beginning on page 49 for Retiree Medical Program E – HDHP, page 95 for Retiree Medical Program E – CDHP 80,
Home infusion therapy after the transplant occurrence;

- Residential Treatment Centers, and, if applicable, the specific program, unless licensed by the state and accredited by CARF (Commission on the Accreditation of Rehabilitation Facilities) or COA (Council on Accreditation) or JCAHO (Joint Commission on Accreditation of Healthcare Organizations);

- Cognitive rehabilitation for schizophrenia and Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder; and

- Emotional growth academies, therapeutic boarding schools, wilderness therapy programs, boot camps (also known as behavior modification facilities), military schools and specialty schools (such as those for children with autism spectrum disorder).

**Health Advice Lines**

Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO and Retiree Medical Program E – Indemnity, as well as some local HMOs, provide Health Advice Lines. The Health Advice Lines enable you to speak to a Registered Nurse 24 hours a day who can serve as an information resource for health-related questions and an advocate in using the health care system. By making informed decisions about your personal health care and how you want to access health care services, you may receive better health care and manage your out-of-pocket expenses at the same time.

For example, if you have questions about a recommended course of treatment, the potential side effects of a medication, prenatal concerns, or you just want to talk confidentially with a professional about your health, a nurse will be available to you.

Because these professionals understand the health care system, they can also help you think through questions you might have for your doctor, or evaluate your options if a recommended procedure or treatment is not covered by your program.

Members enrolled in the Retiree Medical Program options can contact the Health Advice Line 24 hours a day at these toll-free numbers:

- Retiree Medical Program E – HDHP (Cigna): 1-888-502-4462
- Retiree Medical Program E – CDHP 80 (Cigna): 1-888-502-4462
- Retiree Medical Program E – CDHP 90 (Cigna): 1-888-502-4462
- Aetna HMO: 1-800-556-1555
- UHC Medicare Advantage HMO Companion Program (UnitedHealthcare): 1-877-365-7949
- Retiree Medical Program E – Indemnity (Cigna): 1-888-502-4462

To determine if a Health Advice Line is available for a local HMO and to obtain the telephone number, call the member services telephone number on your identification card.

**Care Counselor Program**

The Care Counselor Program is available at no cost to non-Medicare-eligible participants in Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO and Retiree Medical Program E – Indemnity. The Care Counselor Program is not available to local HMO, Medicare Advantage Program, Medicare Cost Program or the UHC Companion Coverage participants or to Medicare-eligible participants in Retiree Medical Program.
Program E – Indemnity. However, non-Medicare-eligible Dependents enrolled in the Aetna Companion Coverage are eligible for the Care Counselor Program.

Care Counselors are Registered Nurses and other licensed health care professionals who are available to help if you are going into the Hospital and/or have medical conditions requiring regular care. Care Counselors can also talk with you about treatment alternatives for a condition that you have not been able to manage to your satisfaction, such as high blood pressure, diabetes or back pain. They help you understand your medical condition and support you and your physician during treatment. In addition, a Care Counselor will provide guidance and assistance in the following areas:

- Admission Counseling: The Care Counselor will provide education and information about the treatment you will receive in the Hospital, answer any questions you may have about pre-admission testing, review patient safety procedures and help you identify your needs after leaving the Hospital;

- Inpatient Advocacy: During an Inpatient Hospital stay, the Care Counselor will monitor your condition and progress, and assess your changing needs after you leave the Hospital; and

- Discharge and Home Counseling: The Care Counselor will provide post-hospitalization information about your recovery period, and will work with you and your doctor to address any unmet health care needs or services.

The list of conditions addressed by Cigna’s Care Counselors includes stress, weight, tobacco, asthma, heart disease, coronary artery disease, angina, congestive heart failure, acute myocardial infarction, COPD, diabetes type 1 & 2, metabolic syndrome, peripheral arterial disease, low back pain, osteoarthritis, depression, anxiety and bi-polar disorder.

Aetna’s Care Counselors can help you with your questions about any medical issue, treatment or condition, while connecting you to the tools and services you need most. They can answer your health care questions and concerns regarding an ongoing or new diagnosis, help you understand recommended tests, treatments and medications, and can coordinate transfers between Hospitals and other medical facilities. They can connect you to the health care you need, if and when you need it.
Filing Claims

Below you will find information about filing claims to receive reimbursement for medical expenses. It is important to remember that your Program provides reimbursement for Covered Expenses only.

If you have questions about a claim or need help filing a claim under one of the Retiree Medical Program options, call your health care carrier’s member services department.

When You Must File a Claim

- If you are not Medicare-eligible, you and your Qualified Dependents must file a claim whenever you obtain Out-of-Network care under Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80 or Retiree Medical Program E – CDHP 90, or for all covered medical expenses under Retiree Medical Program E – Indemnity Program; or
- If you are Medicare-eligible, you and your Qualified Dependents must file a claim for all covered medical expenses under Retiree Medical Program E – Indemnity.

How to File a Claim

When you are required to file a claim (see “When You Must File a Claim” above), you will need to fill out a claim form. Claim forms are available on the Prudential Benefits Center website (at www.prubenefitscenter.com), or from your health care carrier’s member services department.

Here are some tips to help you:

- Follow the instructions on the form and be sure to fill it out completely. If you leave out any information, it will take longer to process your claim and you will have to wait longer for reimbursement;
- Attach an original itemized bill to your completed claim form. An itemized bill shows your name, the doctor’s name and address, the illness or injury treated, services provided and the amount charged for each service. Remember to make a copy of the bill and keep it for your own records;
- Mail the completed form, with the itemized bill attached, to the address on the form; and
- Remember to file your claim for benefits as soon as possible after the circumstances creating the claim take place (for example, illness, injury). You are entitled to file a claim for benefits to which you believe you are entitled, up to one year from the date your claim arose.

The Explanation of Benefits Statement

Once your claim is processed, you will receive an Explanation of Benefits (EOB) statement. This statement shows how your claim was processed and what benefits were paid.

How Benefits Are Paid

The reimbursement check will be sent to your health care provider, if you have given permission for this to be done. You give permission by signing the “Assignment of Benefits” portion of the claim form. If you do not sign this portion of the form, the reimbursement check will be mailed to you.

Once benefits are paid, you will be responsible for paying any charges that were not reimbursed. This includes any charges for services or supplies that are not covered under your program.

If your claim is denied, you have the right to appeal the decision. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information.) You can also contact your health care carrier or HMO for information on how to appeal a denied benefits claim.

To have your claim for benefits considered, you need to file your claim within one year from the date the claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. If you fail to meet the deadline, your claim will be denied.
Non-Duplication of Benefits Provision

If you are covered under another medical program (for example, if you are covered as a Qualified Dependent under your Spouse’s medical program), that program’s benefits will be coordinated with the benefits provided under the Prudential Retiree Medical Program. This provision is called “Non-Duplication of Benefits” and makes sure that your Prudential benefits, combined with other group health benefits, will not pay more in benefits than the Prudential Retiree Medical Program would have paid if it were the only medical program you had.

Non-Duplication of Benefits provisions may differ among local HMOs, Medicare Advantage Programs or the Medicare Cost Program. Please contact your carrier’s member services for more information.

If both you and your Spouse or Qualified Adult are Prudential Retirees, or if your Spouse is a Prudential Employee, you may each be covered individually, or one of you can provide coverage for both of you. However, you cannot be covered as both a Retiree and a Qualified Dependent under the Retiree Medical Program at the same time.

How Non-Duplication of Benefits Works

Under a Non-Duplication of Benefits provision, benefits will be paid only up to the level of payment you would have received if your Prudential Retiree Medical Program were the only program you had. Unlike a Coordination of Benefits provision, where two programs coordinate benefit payments up to 100% of Covered Charges, a Non-Duplication of Benefits provision seeks to maintain the level of benefits you would have received if the Prudential Retiree Medical Program were your primary medical program.

If Your Qualified Dependent Used an Out-of-Network Provider

For example, suppose your Spouse is covered under his/her employer’s program and that program pays benefits based on 80% of Reasonable and Customary (R&C) Fees. You cover your Spouse as a Qualified Dependent under the CDHP 90. Your Spouse incurs expenses of $100 for an Office Visit and related services using an Out-of-Network provider. Assuming your Spouse has met the annual Deductible for both programs and that the $100 does not exceed the R&C Fee, his/her employer’s program would pay $80 toward Covered Expenses.

Your Spouse could then submit a claim for reimbursement to the CDHP 90 for Out-of-Network care. The CDHP 90 would have paid 70% of $100, or $70, if it were the primary program. However, since your Spouse has already received benefits of $80 under his/her employer’s program, and the CDHP 90 would have paid only $70 if it were the primary program, the CDHP 90 would pay no benefits toward this claim.

If Your Qualified Dependent Used a Participating Provider

Assume that your Spouse had $200 of Covered Charges and his/her program paid 70% or $140 toward Covered Expenses, and that your Spouse has met the annual Deductible for both programs. In this case, the provider also participates in the CDHP 90 network. When your Spouse receives his/her reimbursement of $140, he/she can submit a claim to the CDHP 90. Under the CDHP 90, your Spouse would have paid $20 and the CDHP 90 would have paid $180 toward Covered Services. Because your Spouse’s program has already paid $140, the CDHP 90 would reimburse your Spouse $40 ($180 - $140 = $40).

If you are considering coverage for yourself or your Qualified Dependents under more than one medical program, it is important to compare the benefits payable under each to determine if duplicate coverage makes sense for you.

Please note: The Retiree Prescription Drug Program and Prescription Drug coverage under Retiree Medical Program E – HDHP do not follow the “Non-Duplication of Benefits” provision. Instead, the Retiree Prescription Drug Program and Prescription Drug coverage under Retiree Medical Program E – HDHP follow a Coordination of Benefits provision, as described under “Coordination of Benefits for Prescription Drugs” beginning on page 40 and “Coordination of Benefits for Prescription Drugs” beginning on page 70.
**Which Medical Program Pays Benefits First**

**For You and Your Spouse or Qualified Adult**

The program that covers a person as an employee or a retiree will pay benefits first. For example, if you are covering your Spouse/Qualified Adult and your Spouse/Qualified Adult has coverage through his/her own employer, your Spouse/Qualified Adult’s employer would be primary and the Retiree Medical Program would be secondary for your Spouse/Qualified Adult.

**For Covered Dependent Child(ren)**

For covered Dependent Children, the “birthday rule” is used to determine which program provides primary coverage and which program provides secondary coverage when both parents cover the Dependent Child(ren). The program of the parent whose birthday (month and day, but not year) falls earlier in the year is primary. For example, if your birth date is April 3, 1952, and your Spouse’s birth date is April 1, 1954, your Spouse’s program will pay first.

For Dependent Children of divorced or separated parents with coverage under two or more programs, the primary program will be determined in the following order (unless stated otherwise by a court decree):

- The program of the parent with custody of the child;

- The program of the Spouse of the parent with custody of the child; then

- The program of the parent with a court order setting responsibility for health care expenses.

**Non-Duplication of Benefits in Accidents**

In addition, if you or your Qualified Dependents are injured in an accident, such as an automobile accident, and receive medical benefits through the Prudential Retiree Medical Program, injury claims must be evaluated and investigated to determine how the injury was caused. Your health care carrier will determine if another person, organization or liability insurance carrier, such as a no-fault insurance carrier, is responsible for reimbursing the health care carrier for the benefits provided. Once the liability of the third party is identified, then a claim must be made against that party, and liability for reimbursement is established. Any of the Retiree Medical Program options is entitled to reimbursement by the third party for all or part of the medical benefits the Retiree Medical Program provided. (See “Recovery of Benefits if Payable by a Third Party” beginning on page 213 for more information.)
**Medicare and Your Retiree Medical Program**

When you or any of your Covered Qualified Dependents become eligible for Medicare, your Prudential coverage will continue. However, your Retiree Medical Program benefits will be calculated differently if you become eligible for Medicare. The information below will help you understand how Medicare works and how it affects your benefits under the Prudential Retiree Medical Program.

**About Medicare**

Generally, if you are age 65 or older, you are eligible for Medicare. Under certain circumstances, people who are disabled become eligible for Medicare prior to attaining age 65. Medicare is a Federal health insurance program designed for people age 65 and older, as well as people of any age who have been receiving Social Security disability benefits for 24 months.

Medical coverage under Medicare has two parts for medical and one part for Prescription Drugs:

- **Part A**—Hospital insurance. Part A covers Inpatient Hospital expenses, Inpatient skilled nursing facility services, and Home Health Care and hospice services. When you reach age 65, you are automatically eligible for Part A. It is provided at no cost to you if:
  
  — You are at least 65 years old and have applied for or established entitlement to Social Security; or
  
  — You have been receiving Social Security disability benefits for 24 months; and

- **Part B**—Supplemental medical insurance. Part B helps pay for physicians’ services and certain other out-of-Hospital expenses not covered by Part A. You must enroll in Part B and pay a monthly premium.

Medicare Part D offers optional Prescription Drug coverage to Medicare participants. Medicare Part D requires you to pay a monthly premium. Medicare Part D enrollment is voluntary and you may find that you will not need to enroll if you are satisfied with the benefits your Prescription Drug coverage provides through or in conjunction with your Prudential Retiree Medical Program, although this is a question you must decide on your own after you compare the Prudential program to the Medicare Prescription Drug plans in your area. If you enroll, the Medicare Part D Prescription Drug coverage will be primary and the Prescription Drug coverage provided through or in conjunction with your Prudential Retiree Medical Program will be secondary.

**Enrolling in Medicare Part B**

You may enroll in Medicare Part B:

- During the period that starts three months before and ends three months after you turn age 65;

- When you turn 65 and your coverage under the Prudential Medical Program is terminated; or

- After you have received Social Security disability benefits for 24 months.

After this, you may enroll only between January 1 and March 31 of each year. If you enroll late, your Medicare coverage will start on July 1 following the month you enrolled. While you are not required to enroll in Medicare immediately after turning age 65, you may pay more for it if you wait. For each 12-month period beyond age 65 that you delay enrollment, your monthly Part B premium may be increased.

**Please note:** It is in your best interest to enroll in both Medicare Parts A and B as soon as you are eligible. Your eligibility for Medicare impacts benefits you may receive from the Prudential Retiree Medical Program. If you do not enroll in Medicare Parts A and B, your health care coverage will be reduced by what Medicare would have paid whether or not you enroll in Medicare Parts A and B. Additionally, if your enrollment in Medicare Part B is considered “late,” your premiums for that coverage are increased in the future.
For more information about Medicare, contact your local Social Security office.

**About Medigap or Medicare Supplement Insurance**

While Medicare pays for many basic health care services, it will not pay all medical expenses. To pick up where Medicare leaves off, many private insurance companies offer individual Medigap or Medicare Supplement insurance policies. It is important to understand that Prudential’s Retiree Medical Program is not a Medigap or Medicare Supplement plan.

**How Medicare Affects Your Prudential Benefits**

If you or your Qualified Dependent is eligible for Medicare, the benefits paid by your Retiree Medical Program E – Indemnity coverage will be reduced by the value of any Medicare benefits for which you are eligible, whether or not you or your Qualified Dependent is covered by Medicare Part A or Part B. This provision makes sure that your Medicare and Prudential benefits combined will not be more than what the Prudential Retiree Medical Program would have paid.

**How Medicare Affects Your Retiree Medical Program Options**

Upon your attainment of Medicare eligibility, you and your Covered Qualified Dependents will be enrolled in Retiree Medical Program E – Indemnity unless you enroll in a Medicare Advantage Program or Medicare Cost Program (if available in your area). (See your Program’s summary of benefits chart for more information.) If your Qualified Dependent becomes Medicare-eligible, but you do not become Medicare-eligible, coverage for you and all of your Covered Qualified Dependents will continue under your current Program (HDHP, CDHP 80, CDHP 90 or HMO) until you become Medicare-eligible.

**Adjustments to Medicare Premiums**

Medicare premiums for Part B and Part D may be increased for one or both of the following reasons:

- Higher income participants or beneficiaries may be subject to higher premiums based on their modified adjusted gross income. These higher premiums are often referred to as Income Related Medicare Adjustment Amounts (IRMAA). You will be notified by Medicare if you are affected. IRMAA payments generally are made by deduction from your Social Security benefit; and

- If you do not enroll in Medicare Part B or Part D when first eligible, you may have to pay a late enrollment penalty (LEP), which is a permanent increase in your premium, when you ultimately enroll, unless you meet certain conditions.

If either of these scenarios applies to you, you must pay your increased Part B and/or Part D (if applicable) premiums to remain in good standing and enrolled in your selected Medicare Advantage Program or Medicare Cost Program.

Lower income participants or beneficiaries may be eligible for subsidies to help pay for Medicare coverage. These low income subsidy (LIS) programs are:

- Extra Help to pay for prescription drug coverage under Part D; and

- Medicare Savings Programs, which are various programs available from your state, to assist you in paying Medicare Part A and/or Part B premiums, deductibles, coinsurance and copays.

Information about all of these premium adjustments and assistance programs is available on the Medicare website at www.medicare.gov or by calling 1-800-MEDICARE (1-800-633-4227).

**Assignment of Medicare Benefits**

When a doctor “accepts assignment” from Medicare, he/she agrees to charge no more than Medicare’s Reasonable and Customary (R&C) Fee (also called the approved amount) as determined by Medicare. Any portion of the fee in excess of Medicare’s R&C Fee is not an Eligible Expense, under either Medicare or the Retiree Medical Program, and the doctor may not collect that excess charge from you. However, you would be responsible for any annual Deductible and Coinsurance amounts related to the R&C Fee under both Medicare and the Retiree Medical Program.
Doctors who accept assignment from Medicare are called Medicare participating physicians. Those who do not are called non-Medicare participating physicians.

If You Need Help

If you are not sure which program you should file claims with first, call your health care carrier’s member services department. You should send copies of all claims to all programs that cover you. Along with your claim forms, you should include copies of any Explanation of Benefits statements you have received from other insurers, plus actual bills and receipts that apply to your claims. When your claims are processed, you may be asked to provide other information as well.
When Medical Coverage Ends

When Your Medical Coverage Ends
Your coverage under the Retiree Medical Program will end at the end of the month during which:

- You cancel your coverage;
- You fail to make any required contributions (you are covered only for the months for which you contribute). For example, if you contribute for January, February and March, you only have coverage through the end of March. You have no coverage in April; or
- Your Long Term Disability benefits end for any reason and you were not eligible to Retire when Long Term Disability benefits commenced and you have not reached the maximum benefits duration.

Your coverage under the Retiree Medical Program will end on the date when:

- You present a fraudulent claim for benefits;
- You are rehired by Prudential\(^{11}\); or
- Prudential terminates the Retiree Medical Program.

Please note: If you retired on or after January 1, 2008, you are a Long Term Disability participant, or you are a Surviving Dependent, once you enroll in the Retiree Medical Program, and your coverage is discontinued for any reason, you will not be permitted to re-enroll in the Retiree Medical Program at any time.

Please note: You may retain your Health Savings Account (HSA) administered by JPMorgan Chase if your coverage ends or you stop participating in Retiree Medical Program E – HDHP. You will be responsible for paying the monthly account maintenance fees and investment fees. You will receive information from JPMorgan Chase explaining your options. If you do not make an election, your HSA will transition automatically to an HSA independently owned by you and administered by JPMorgan Chase. For more information, you may contact JPMorgan Chase by visiting the JPMorgan Chase website at www.chase.com/hsa or by calling JPMorgan Chase at 1-866-524-2483.

When Qualified Dependent Coverage Ends
Coverage for a Qualified Dependent under the Retiree Medical Program will end at the end of the month during which:

- You cancel your coverage;
- Your coverage ends;
- You fail to make any required contributions (you are covered only for the months for which you contribute). For example, if you contribute for January, February and March, you only have coverage through the end of March. You have no coverage in April;
- Your Qualified Dependent becomes covered as an Employee;
- You cancel coverage for that Qualified Dependent; or

\(^{11}\) Please call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) for information about eligibility for Prudential-sponsored medical coverage if you are rehired by Prudential.
• Your Qualified Dependent no longer qualifies for coverage. (See the criteria described in the Glossary definitions of “Spouse,” “Qualified Adult,” “Domestic Partner,” “Extended Family Member,” “Dependent Child(ren),” “Qualifying Child” or “Qualifying Relative.” Age limitations apply for Extended Family Member and Dependent Child coverage. Please see the Glossary beginning on page 217 for more information.)

Coverage for a Qualified Dependent under the Retiree Medical Program will end on the date when:

• You present a fraudulent claim for benefits;

• Your Qualified Dependent presents a fraudulent claim for benefits;

• Prudential terminates the Retiree Medical Program; or

• Prudential terminates all Qualified Dependent coverage under the Retiree Medical Program.

Notification
If your Qualified Dependent no longer qualifies for coverage (for example, if your Dependent Child becomes a full-time employee or you and your Spouse become divorced), you must submit notification of this change immediately via the Prudential Benefits Center website at www.prubenefitscenter.com by removing your ineligible dependent from coverage. Or, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits, and explain that you need to remove an ineligible dependent from coverage.

If you have the RMSA for financial support and the Qualified Dependent whom you have listed as eligible for reimbursement from your RMSA no longer qualifies as a Dependent, you should notify UnitedHealthcare, the RMSA administrator, immediately of the change by calling 1-866-278-0771.
Administrative Information

This Retiree Medical Program SPD booklet is intended to describe the specific provisions of the Retiree Medical Program options available to eligible Retirees of Prudential, Long Term Disability participants and Surviving Dependents under The Prudential Welfare Benefits Plan through March 30, 2014, and The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. In addition to knowing these provisions, you need to be aware of important administrative details, including what steps you may take if you believe that a claim has been wrongfully denied. You also need to know about your legal rights as a participant in the Program under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

The Prudential Retiree Welfare Benefits Plan Effective March 31, 2014

The Prudential Retiree Welfare Benefits Plan was established by the Company effective January 1, 2014, to provide various retiree health and welfare benefits previously provided by The Prudential Welfare Benefits Plan. Specifically, Retiree Medical Program benefits are provided under The Prudential Welfare Benefits Plan effective March 31, 2014. All references to The Prudential Welfare Benefits Plan in this SPD booklet should be read to refer to The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All other terms, conditions, limitations and exclusions of this SPD booklet are hereby incorporated and form the Summary Plan Description for The Prudential Retiree Welfare Benefits Plan.

This SPD booklet constitutes the Summary Plan Description of the Retiree Medical Program of The Prudential Welfare Benefits Plan, effective as of January 1, 2013, through March 30, 2014, and The Prudential Retiree Welfare Benefits Plan effective March 31, 2014, except as noted, and provides important information about your rights under ERISA.

This SPD booklet should in no way be considered a substitute for the applicable Plan Document, which governs the operation of the Program.

If you have any questions regarding this Retiree Medical Program SPD booklet, please visit the Prudential Benefits Center website (at www.prubenefitscenter.com), or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Plan Administration and Funding

Plan Name and Number


<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Plan Number</th>
<th>Type of Plan</th>
<th>Plan Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Prudential Welfare Benefits Plan</td>
<td>501</td>
<td>Welfare (Medical)</td>
<td>The Administrative Committee</td>
</tr>
<tr>
<td>The Prudential Retiree Welfare Benefits Plan</td>
<td>511</td>
<td>Welfare (Medical)</td>
<td>The Administrative Committee</td>
</tr>
</tbody>
</table>

Plan Administrator

The Plan Administrator for the Retiree Medical Program is the Administrative Committee (which is responsible for administering matters under the Retiree Medical Program). The address for the Plan Administrator is:
Plan Sponsor
The sponsor for the Retiree Medical Program described in this SPD booklet is:

The Prudential Insurance Company of America
Prudential Plaza
751 Broad Street
Newark, NJ 07102-3777
Telephone: 1-973-802-6000

Employer Identification Number
The Company's employer identification number, assigned by the Internal Revenue Service, is 22-1211670.

Plan Year
The Plan Year is the 12-month period used for maintaining the Retiree Medical Program's financial records. The official Plan Year for the Retiree Medical Program is January 1 through December 31 of each Calendar Year.

Funding, Payment and Claims of Program Benefits
The Retiree Medical Program is a component of The Prudential Welfare Benefits Plan and benefits are funded by a combination of insurance, employer payments and trust funds.

Trustee Information
Assets under The Prudential Welfare Benefits Plan are held both in trusts and pursuant to insurance contracts issued by various HMOs. Other than the insurance policies described below, the Trustee of the trusts for the benefit of The Prudential Welfare Benefits Plan is:

Prudential Trust Company
30 Scranton Office Park, Mailstop 330
Scranton, PA 18507
Telephone: 1-570-341-6280

Insurance Issuers and Administrators
The following lists insurance companies and HMOs, Medicare Advantage Programs and the Medicare Cost Program ("providers") and their roles in providing benefits under the Program. “ASO” refers to the contract that provides only administrative services but no guarantee by the provider. “Insurance” refers to a contract providing a full guarantee by the providers.
<table>
<thead>
<tr>
<th>Retiree Medical Program Option</th>
<th>Provider</th>
<th>Provider Roles*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Programs</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Retiree Medical Program E – High Deductible Health Program | Cigna HealthCare 900 Cottage Grove Road Hartford, CT 06152 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Retiree Medical Program E – Consumer Directed Health Program 80 | Cigna HealthCare 900 Cottage Grove Road Hartford, CT 06152 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Retiree Medical Program E – Consumer Directed Health Program 90 | Cigna HealthCare 900 Cottage Grove Road Hartford, CT 06152 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Aetna HMO                     | Aetna Life Insurance Company 151 Farmington Avenue Hartford, CT 06156 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Retiree Medical Program E – Indemnity | Cigna HealthCare 900 Cottage Grove Road Hartford, CT 06152 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| **Retiree Prescription Drug Program** |          |                |
| Retiree Prescription Drug Program | Express Scripts 100 Parsons Pond Drive Franklin Lakes, NJ 07417 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| **Local HMO Programs**        |          |                |
| HealthPartners                | HealthPartners Medical Claims P.O. Box 1289 Minneapolis, MN 55440-1289 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Horizon HMO                   | Horizon BCBS of NJ P.O. Box 820 Newark, NJ 07105 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| Kaiser – Hawaii               | Kaiser Foundation Health Plan, Inc. Attn. Claims Administration Department 80 Mahalani Street  Wailuku, HI 96793 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |
| Medical Associates            | Medical Associates 1605 Associates Drive, Suite 101 Dubuque, IA 52004-5002 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |

Table and footnote continue through page 196
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<thead>
<tr>
<th>Retiree Medical Program Option</th>
<th>Provider</th>
<th>Provider Roles*</th>
</tr>
</thead>
</table>
| Tufts Health Plan             | Tufts Health Plan | • Insurance  
Member Reimbursement Claims | • Claims Administrator  
P.O. Box 9191 | • Claims Fiduciary  
Watertown, MA 02471-9191 |

**Medicare Advantage Programs**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Provider Roles*</th>
</tr>
</thead>
</table>
| Aetna Life Insurance Company | • Insurance  
151 Farmington Avenue | • Claims Administrator  
Hartford, CT 06156 | • Claims Fiduciary  
Companion coverage only |
| Health Plan Nevada Medicare Advantage HMO – Nevada (Program terminated effective December 31, 2013) | Same as above  
Senior Dimensions  
Attn: Claims Administration | • ASO  
P.O. Box 15645  
Las Vegas, NV 89114-5645 | • Claims Administrator  
• Claims Fiduciary  
Humana Medicare Advantage HMOs – Arizona, Florida, Illinois, Missouri | | • Insurance  
P.O. Box 14601  
Lexington, KY 40512 | • Claims Administrator  
• Claims Fiduciary  
MVP Health Care Medicare Advantage HMO – W/C New York | Medical Claims  
MVP Health Care  
P.O. Box 2207  
Schenectady, New York 12301 | • Insurance  
• Claims Administrator  
• Claims Fiduciary  
Tufts Medicare Advantage HMO – Massachusetts | Tufts Health Plan Medicare Preferred  
705 Mt. Auburn Street  
Watertown, MA 02472 | • Insurance  
• Claims Administrator  
• Claims Fiduciary  
Table and footnote continue through page 196
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<thead>
<tr>
<th>Retiree Medical Program Option</th>
<th>Provider</th>
<th>Provider Roles*</th>
</tr>
</thead>
</table>
| UHC Medicare Advantage HMO – Alabama, Arizona, Florida, Georgia, Iowa, Michigan, Missouri, North Carolina, Ohio, Rhode Island, SW Illinois, Tennessee, Wisconsin | UnitedHealthcare Medicare Advantage Customer Service P.O. Box 31362 Salt Lake City, UT 84131-0362 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – California | UnitedHealthcare Medicare Advantage  
Customer Service  
5701 Katella Avenue  
P.O. Box 489  
Cypress, CA 90630 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – California | UnitedHealthcare  
P.O. Box 740800  
Atlanta, GA 30374 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – Colorado | UnitedHealthcare Medicare Advantage  
Customer Service  
P.O. Box 6770  
Englewood, CO 80155 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – Colorado | UnitedHealthcare  
P.O. Box 740800  
Atlanta, GA 30374 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – Connecticut, New Jersey, SE New York | UnitedHealthcare Medicare Advantage by UHC/Oxford Claims P.O. Box 7082 Bridgeport, CT 06601 | • Insurance  
• Claims Administrator  
• Claims Fiduciary |
| UHC Medicare Advantage HMO – Connecticut, New Jersey, SE New York | UnitedHealthcare  
P.O. Box 740800  
Atlanta, GA 30374 | • ASO  
• Claims Administrator  
• Claims Fiduciary |
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<tbody>
<tr>
<td><strong>UHC Medicare Advantage HMO – Nevada</strong></td>
<td>UnitedHealthcare Medicare Advantage Customer Service 700 East Warm Springs Road Suite 302 Las Vegas, NV 89119</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td>Companion coverage only</td>
<td>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td><strong>UHC Medicare Advantage HMO – Oklahoma</strong></td>
<td>UnitedHealthcare Medicare Advantage Customer Service P.O. Box 400055 San Antonio, TX 78229</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td>Companion coverage only</td>
<td>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td><strong>UHC Medicare Advantage HMO – Texas</strong></td>
<td>UnitedHealthcare Medicare Advantage Customer Service P.O. Box 29127 San Antonio, TX 78229</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td>Companion coverage only</td>
<td>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td><strong>UHC Medicare Advantage HMO – Washington</strong></td>
<td>UnitedHealthcare Medicare Advantage Customer Service P.O. Box 6093 Cypress, CA 90630</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td>Companion coverage only</td>
<td>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
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<tr>
<td><strong>UHC Medicare Advantage HMO – W/C New York</strong></td>
<td>UnitedHealthcare Medicare Advantage 5015 Campuswood Drive Suite 107 East Syracuse, NY 13057</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
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<tr>
<td>Companion coverage only</td>
<td>UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td><strong>Medicare Cost Program</strong></td>
<td>HealthPartners Medical Claims P.O. Box 1289 Minneapolis, MN 55440-1289</td>
<td>• Insurance  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td>Companion coverage only</td>
<td>Same as above</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
<tr>
<td><strong>Retiree Medical Savings Account (RMSA)</strong></td>
<td>UnitedHealthcare Service Center P.O. Box 981506 El Paso, TX 79998-1506</td>
<td>• ASO  • Claims Administrator  • Claims Fiduciary</td>
</tr>
</tbody>
</table>

*Note: For program enrollment and eligibility claims, the Prudential Benefits Center is the Claims Administrator and the Administrative Committee is the Claims Fiduciary.

**Plan Amendment or Termination**

The Company has reserved the right, subject to applicable law, to amend, modify, suspend or terminate The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Benefits Plan, including, but not limited to, the Retiree benefits discussed in this SPD booklet, in whole or in part. Any such action would be taken in writing and maintained with the records of The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Benefits Plan, as applicable. Plan amendment, modification, suspension or termination may be made for any reason, and at any time. Such amendments may be made retroactive if necessary to meet statutory requirements or for any other appropriate reason.

Upon termination of The Prudential Welfare Benefits Plan or The Prudential Retiree Welfare Benefits Plan, Prudential shall determine in accordance with applicable law, how the remaining assets of The Prudential Welfare Benefits Plan or The Prudential Retiree Welfare Benefits Plan will be distributed.

The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Benefits Plan describe the procedures for amending or terminating the applicable Plan and who may make amendments.

**Assignment of Benefits**

The programs summarized in this Retiree Medical Program SPD booklet are used exclusively to provide benefits to you, and, in some cases, to your eligible Qualified Dependents. You cannot assign ownership of your medical benefits.
Qualified Medical Child Support Order

Federal law permits assignment of benefits to your child(ren) under The Prudential Welfare Benefits Plan through a court order referred to as a Qualified Medical Child Support Order (QMCSO). The Prudential Welfare Benefits Plan and The Prudential Retiree Welfare Benefits Plan honors QMCSOs issued under state domestic law that requires health benefits to be provided to a child. A QMCSO is an order or judgment from a state court—served on the Company or agent for service of legal process—directing the Plan Administrator to cover a child for benefits under the health care plan.

You or your family may obtain, without charge, a copy of The Prudential Welfare Benefits Plan’s QMCSO procedures and other information about QMCSOs from the Prudential Benefits Center by calling 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.

National Medical Support Notice

The Administrative Committee will consider any National Medical Support Notice as a QMCSO. Upon receipt of such a Notice (issued with respect to the child of a participant who is such child’s non-custodial parent) that meets the requirements of a QMCSO, the Administrative Committee will inform the issuing state agency of the benefits available to the child and all procedures necessary to enroll the child in such benefits. The custodial parent will also be notified of available coverage and will be provided any forms or documents necessary to enroll the child in such coverage. The non-custodial parent will be liable to The Prudential Welfare Benefits Plan to pay for all Retiree contributions required under The Prudential Welfare Benefits Plan for the enrollment of the child.

Claims, Claims Appeals and External Claims Review Procedures

You, or any person you choose to represent you, must follow the claims, claims appeals and external claims review procedures outlined below before taking action in any other forum regarding a claim under The Prudential Welfare Benefits Plan.

The Plan Administrator or its delegate will process any writing that is identified as a claim for benefits (either by the claimant or, if the writing is not specific, by the Plan Administrator) under the claims, claims appeals and claims review procedures outlined below. If your claim is not identified as a claim for benefits, the Plan Administrator or its delegate will treat your writing or communication as a claim under the Non-Benefit Claims procedures beginning on page 205.

Enrollment and eligibility claims will be identified as Non-Benefit Claims and will be processed under the Non-Benefit Claims procedures beginning on page 205 unless they are part of a claim for health care benefits. For example, if you file a claim for benefits that is denied because you are not eligible to participate in the Retiree Medical Program, your claim will be considered a claim for benefits and will follow the procedures outlined in the “Claim for Benefits” section beginning below. For all enrollment and eligibility claims, including those considered a claim for benefits, the Prudential Benefits Center is the Claims Administrator and the Administrative Committee is the Claims Fiduciary.

If your claim for benefits is denied, it will be considered an Adverse Benefit Determination. An Adverse Benefit Determination is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment. You have the right to appeal any Adverse Benefit Determination under the procedures described below. A claim shall be considered approved only if approval is communicated to you in writing. If you do not receive a response to any claim within the applicable time period, you may proceed with an appeal under the procedures described below.

If your appeal is denied, you may be eligible for a second level of appeal or for an external review of your claim for benefits under the procedures described below.

Claim for Benefits

Making a Claim for a Benefit

When you apply for or request a benefit in any manner, this will generally constitute a claim. The information below will tell you exactly how to file for a benefit under The Prudential Welfare Benefits Plan. There are times when a phone call to the Claims Administrator questioning why you are not...
covered or how to apply for a benefit can constitute a claim. Claims may also include a determination automatically submitted on your behalf by your service provider when you receive a service, even if you have not filled out a form. The Claims Administrator can always give you more information on how to request or apply for a benefit.

**How to File a Claim for Benefits**

**Under Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80 and Retiree Medical Program E – CDHP 90:** There are no claim forms required for In-Network services. You must file a claim form for all Out-of-Network care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses once your annual Deductible (if applicable) is met. You will receive your claim reimbursement following the receipt and approval of your completed form and the processing of your claim.

Claim forms are available on the Prudential Benefits Center website at [www.prubenefitcenter.com](http://www.prubenefitcenter.com) or from Cigna directly by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

**Under the HMOs, Medicare Advantage Programs and the Medicare Cost Program:** There are no claim forms to file for In-Network care under the HMO, Medicare Advantage Programs and the Medicare Cost Program. Your provider will submit claims directly to the HMO, Medicare Advantage Program or Medicare Cost Program on your behalf. If you receive Emergency care outside the HMO, Medicare Advantage Program or Medicare Cost Program network area, contact your HMO, Medicare Advantage Program or Medicare Cost Program for information about how to file for reimbursement.

**Under Retiree Medical Program E – Indemnity:** You must file a claim for all Retiree Medical Program E – Indemnity care and services and provide itemized bills and receipts. You usually pay at the time of service, then submit a claim form for the Program to reimburse you for a percentage of Covered Expenses once your annual Deductible (if applicable) is met. You will receive your claim reimbursement following the receipt and approval of your completed form. Claim forms are available on the Prudential Benefits Center website at [www.prubenefitcenter.com](http://www.prubenefitcenter.com) or from Cigna directly by calling Cigna member services at 1-888-502-4462 or by printing the forms from the Cigna custom website for Prudential (at [www.cigna.com/prudential](http://www.cigna.com/prudential)).

**Please note:** Presenting your prescription to a pharmacy under the Retiree Prescription Drug Program administered by Express Scripts or the HDHP does not constitute a claim for benefits. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim. You must file a claim form with Express Scripts member services directly if you feel you were denied a covered benefit.

**What Information to Include in a Claim**

Your claim should state your name, address, the specific basis for your claim and any additional materials you wish to present. This information may automatically have been provided by your service provider’s office. Note that claims can often be filed online or by phone. Call the Claims Administrator for more information. Benefits under each ERISA-governed plan will be paid only if the applicable Claims Fiduciary decides in its sole discretion that the claimant is entitled to them.

**When to File a Claim**

The best time to file a claim for benefits is as soon as possible after the circumstances creating the claim take place (for example, illness, injury). You are entitled to file a claim for benefits to which you believe you are entitled, up to one year from the date your claim arose. A claim will be presumed to have arisen when you have actual or constructive notice of the events giving rise to the claim.

**Urgent Care Claims**

Notice of a decision on your claim for benefits (whether adverse or not) must be provided no later than 72 hours, after receipt of your claim by the Claims Administrator. If you fail to provide sufficient information to determine whether benefits are covered or payable under The Prudential Welfare Benefits Plan, you must be notified within 24 hours about the information needed to complete your
claim. You will then have at least 48 hours to provide the information. The Claims Administrator will then notify you of your benefit determination no later than 48 hours, from the earlier of the receipt of any additional information you provide or the end of the period afforded to you to provide the specified additional information.

An Urgent Care Claim means any health claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

The Claims Administrator determines whether a claim is an Urgent Care Claim on the basis of information provided by you or your representative. You must provide specific information regarding whether and what medical circumstances exist that may give rise to a need for expedited processing as an Urgent Care Claim. Any claim that a physician with knowledge of your medical condition determines is a claim involving urgent care will be treated as an Urgent Care Claim.

**Concurrent Care Claims**

If an ongoing course of treatment has been approved, any reduction or termination of such course of treatment before the end of the period will be considered an Adverse Benefit Determination. The Claims Administrator will notify you sufficiently in advance of the reduction or termination to allow you to request an appeal.

If you have been notified that an ongoing course of treatment must be reduced or terminated, your request to extend the course of treatment that is an Urgent Care Claim must be decided as soon as possible based on the medical circumstances and you must be notified of the decision within 24 hours after receipt of your claim by the Claims Administrator, provided that your claim is made at least 24 hours before the expiration of the prescribed period of time or number of treatments. If your request is not made at least 24 hours before your treatment expires, your request shall be treated as an Urgent Care Claim and decided as soon as possible but not later than 72 hours after receipt of your request, unless it does not involve urgent care. If your request does not involve urgent care, it shall be treated as a Pre-Service Claim or a Post-Service Claim.

**Pre-Service Claims**

Notice of a decision on your claim for benefits (whether adverse or not) must be provided by the Claims Administrator no later than 15 days after receipt of your claim. If the Claims Administrator determines that, due to matters beyond the control of The Prudential Welfare Benefits Plan, an extension of time is necessary, you must be provided with notice of the extension before the end of the initial 15-day period. The notice must explain the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In no event will the extension exceed an additional 15 days from the end of the initial period. The notice will describe any required information needed and you will have at least 45 days from receipt of the notice to provide this information. If you have submitted additional information to the Claims Administrator, you will receive notice of the decision within 15 days of receipt of the information.

If you fail to follow The Prudential Welfare Benefits Plan’s procedures for filing a Pre-Service Claim, you will be notified (either orally or in writing) and given the proper procedures to be followed. This notice will be provided to you no later than five days (24 hours in the case of a failure to file an Urgent Care Claim) following the failure. This notice requirement will apply only if you or your authorized representative communicate to the Claims Administrator the following information: your name, the specific medical condition or symptom for which you are seeking treatment and the specific treatment, service or product for which you are requesting approval.

A Pre-Service Claim means any health claim which requires approval of the benefit before obtaining medical care.

**Post-Service Claims**

A Post-Service Claim means any health claim that is not a Pre-Service, Concurrent Care or Urgent Care Claim. Notice of an Adverse Benefit Determination must be provided by the Claims Administrator no
later than 30 days after receipt of your claim. If the Claims Administrator determines that, due to matters beyond the control of The Prudential Welfare Benefits Plan, an extension of time is necessary, you will be provided with notice of the extension before the end of the initial 30-day period. The notice will explain the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. In no event will the extension exceed an additional 15 days from the end of the initial period. The notice will describe any required information needed and you will have at least 45 days from receipt of the notice to provide this information. If the period of time is extended because you did not submit information necessary to decide your claim, the period for making the determination will be suspended from the date on which the notice is sent to you until you respond to the request for additional information. If you have submitted additional information to the Claims Administrator, you will receive notice of the decision within 15 days of receipt of the information.

Notice of Adverse Benefit Determination
The written notice of your Adverse Benefit Determination (that is, any denial, reduction, or termination of a benefit, or a failure to provide or make payment) will include the following:

- The specific reason(s) for the Adverse Benefit Determination;
- References to the specific program provisions of The Prudential Welfare Benefits Plan on which the Adverse Benefit Determination is based;
- A description of any additional material or information needed to complete or support your claim, and an explanation of why that material or information is necessary;
- A description of or a copy of The Prudential Welfare Benefits Plan’s appeal and external claims review procedures, the time limits under the procedures, and a statement of your right to bring a civil action under Section 502(a) of ERISA, after you have completed all mandatory appeals and any available external claims review under the program;
- A copy of any internal rule, guideline, protocol or other similar criterion relied upon (if any) in making the Adverse Benefit Determination or a statement that a copy of any internal rule, guideline, protocol or other similar criterion relied upon (if any) in making the Adverse Benefit Determination will be provided to you free of charge upon request;
- If the Adverse Benefit Determination was based on a medical necessity, experimental treatment or similar exclusion or limit, the notice must include either an explanation of the scientific/clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided to you free of charge upon request; and
- If the Adverse Benefit Determination concerns an Urgent Care Claim, a description of the expedited appeal and external review process applicable to such a claim.

No notice is required to be provided to you for a favorable benefit determination, except for an Urgent Care Claim or a Pre-Service Claim.

Appeal of an Adverse Benefit Determination

How to File a Claim for Benefits
If you have followed the above procedures and you have received an Adverse Benefit Determination, you may appeal the decision. Normally, your request must be in writing, but if it is an Urgent Care Claim, the request may be oral. If you desire to appeal, you must ask the appropriate Claims Fiduciary or its delegate to review your Adverse Benefit Determination within 180 days after you receive a notification of an Adverse Benefit Determination. You will have the opportunity to submit written comments, documents, records and other information relating to your claim. You can mail your appeal

\[12\] In the case of an Urgent Care Claim, notice may be provided orally, provided that written notice is provided no later than three days after the oral notification.
to the address noted on your Adverse Benefit Determination notice. If no address is mentioned on your Adverse Benefit Determination notice, contact the carrier’s member services number.

**Access to Records**
Upon your request and free of charge, you will be provided reasonable access to and copies of all documents, records and other information relevant to your claim. When your claim is reviewed, all comments, documents, records and other information that you submitted will be taken into account without regard to whether this information was considered in your initial benefit determination.

**Appeals Procedures**
The following appeals procedures will be provided:

- Your appeal will not give deference to the initial Adverse Benefit Determination on your claim and will be conducted by a Fiduciary of The Prudential Welfare Benefits Plan, as determined by the Administrative Committee or its delegate, who is neither the individual who made your initial Adverse Benefit Determination, nor that individual’s subordinate.

- In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate, the Fiduciary conducting the review shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The medical or vocational experts whose advice was obtained on behalf of The Prudential Welfare Benefits Plan in connection with your previous Adverse Benefit Determination shall be identified, upon your request, without regard to whether the advice was relied upon in making your previous Adverse Benefit Determination.

- The health care professional engaged for purposes of a consultation, shall be an individual who is neither an individual who was consulted in connection with your previous Adverse Benefit Determination, nor the subordinate of any such individual.

- You will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or the Insurer (or at the direction of the Plan or Insurer) in connection with your claim. The evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal Adverse Benefit Determination is required to be provided to you.

- You also will be provided, before issuance of a final internal Adverse Benefit Determination based upon a new or additional rationale, with the rationale. That rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of the final internal Adverse Benefit Determination is required to be provided to you.

- For any Urgent Care Claim, all necessary information, including the Claims Fiduciary’s decision on your appeal, will be transmitted between the Claims Fiduciary and you or your representative by telephone, facsimile or other available similarly expeditious method.

**Time for Determination**
You or your representative will be notified of the Claims Fiduciary’s decision on your appeal within the following time periods:

- In the case of an Urgent Care Claim, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for appeal (if two levels of appeal are available, both decisions must be provided within 72 hours after receipt of your internal request for appeal);
• In the case of a Pre-Service Claim, other than an Urgent Care Claim, within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for appeal and no later than 15 days, if two levels of appeal are applicable; or

• In the case of a Post-Service Claim, within a reasonable period of time, but not later than 60 days after receipt of your request for appeal and no later than 30 days, if two levels of appeal are applicable.

The above periods of time shall begin at the time your appeal is filed in accordance with The Prudential Welfare Benefits Plan’s procedures, without regard to whether all the information necessary to make a benefit determination accompanies your filing.

Notice of Adverse Benefit Determination on Appeal
Your notice of an Adverse Benefit Determination on your appeal will include the following:

• The specific reason or reasons for the Adverse Benefit Determination;

• Reference to the specific provisions of The Prudential Welfare Benefits Plan on which the Adverse Benefit Determination is based;

• A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information that are relevant to your claim for benefits;

• A description of any mandatory or voluntary appeal procedures offered under the Program, a description of the external review procedures, your right to obtain information about such procedures and a statement of your right to bring an action under Section 502(a) of ERISA, after you have completed all mandatory appeals and any external claims review available under the Program;

• A copy of any internal rule, guideline, protocol or other similar criterion relied upon (if any) in making the Adverse Benefit Determination on your appeal or a statement that a copy of any internal rule, guideline, protocol or other similar criterion relied upon (if any) in making the Adverse Benefit Determination on your appeal will be provided to you or your representative free of charge upon request;

• If your Adverse Benefit Determination on appeal was based on a medical necessity, experimental treatment or similar exclusion or limit, the notice must include either an explanation of the scientific/clinical judgment for the determination, applying the terms of the Program to your medical circumstances, or a statement that an explanation will be provided to you free of charge upon request;

• The following statement: “You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency”; and

• You will be advised in your notice of Adverse Benefit Determination whether your claim may be considered under a second level of mandatory appeal or under a voluntary level of appeal. Upon completion of any available second level of mandatory appeal, or of a voluntary appeal (if you choose to exercise any right to a voluntary appeal), your claim may be eligible for an external review, as discussed below.

External Review of an Adverse Benefit Determination
If you receive an Adverse Benefit Determination after you have completed all mandatory levels of appeal, you may be eligible to request an external review. In addition, if you receive an Adverse Benefit Determination on your initial Urgent Care Claim and you qualify for expedited external review, you may be eligible to simultaneously file a request for an external review at the same time as your request for an internal appeal is being processed. You are only eligible for an external review if your claim for benefits involved medical judgment (including, for example, those based on the Retiree Medical Program (Post-2000)—Page 202
Medical Program’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit or a determination as to whether a treatment is Experimental or Investigational) or involved a rescission of coverage, which is a cancellation or discontinuance of medical coverage that is effective retroactively and that is not due to a failure to timely pay required contributions toward the Cost of coverage. In your request for external review, you must provide all forms and information needed to process the review.

Under applicable law, the procedures to follow for external review depend on the Retiree Medical Program option in which you participate, as follows:

**External Review for Retiree Medical Program E – HDHP, Retiree Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO, Retiree Medical Program E – Indemnity and companion coverage under the Aetna and UHC Medicare Advantage Programs**

These Programs are considered self-insured Programs. Under these Programs, a claim is subject to either a standard external review or an expedited external review, as follows:

- **Standard External Review.** Most claims are subject to a standard external review under the following procedures:
  - **Filing Due Date.** Your request for a standard external review must be filed within four months of the date you receive a notice of an Adverse Benefit Determination in the case of a simultaneous internal appeal and external review or the date you receive a final internal Adverse Benefit Determination in the case of all other requests for external review. If there is no corresponding date that is generally four months after receipt of the notice, the filing due date is the first day of the fifth month following receipt of the notice. If the filing due date falls on a Saturday, Sunday or Federal holiday, the filing due date is extended to the next day that is not a Saturday, Sunday or Federal holiday;
  - **Preliminary Review by Administrative Committee, or its Delegate.** Within five business days of the date of receipt of the request for external review, the Administrative Committee, or its delegate, will determine whether your claim is eligible for external review;
  - **Initial Notification.** Within one day thereafter, you will be notified in writing as follows:
    - If your request is complete but your claim is not eligible for external review, the reasons why your claim is ineligible. You will be provided contact information for the Employee Benefits Security Administration of the U.S. Department of Labor; or
    - If your request is not complete, the notice will describe the materials needed to make your request complete. You will have until the later of 48 hours following receipt of the notification, or the filing deadline to complete your request;
  - **Assignment to IRO.** If your request is complete, you are a participant and the claim is eligible for external review, the Administrative Committee, or its delegate, will assign it to an Independent Review Organization (“IRO”). The Plan will provide the IRO the documents and any information the Plan considered in making the final internal Adverse Benefit Determination (or the Adverse Benefit Determination in the case of simultaneous appeal and external review) on your claim;
  - **New Information.** You will be entitled to submit any new information to the IRO and the IRO will forward that information to the Plan. Upon receipt of the new information, the Administrative Committee, or its delegate, may reconsider its Adverse Benefit Determination and reverse it by deciding to provide coverage or payment. If the Administrative Committee, or its delegate, reverses its decision, it will notify you and the IRO, which will then terminate the external review; and
— **Decision and Notice.** The IRO will consider the documents and information provided and provide written notice of the final external review decision to you and to the Plan within 45 days after the IRO receives the request for the external review; and

- **Expedited External Review Procedures.**

You are entitled to an expedited external review if either:

(i) You received a final internal Adverse Benefit Determination, and you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health, or your ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not been discharged from a facility; or

(ii) You received an Adverse Benefit Determination on your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function and you desire to file a request for an expedited external review simultaneously with your filing for an expedited internal appeal.

An expedited external review is subject to the same procedures as a standard external review, as described above, but modified as follows:

— **Preliminary Review.** The determination of whether your request meets the requirements for an external review and whether your claim qualifies for expedited treatment will be made “immediately” upon receipt of your request for an expedited external review. The initial notification to you regarding whether your request meets the standards for an expedited external review will be sent to you “immediately”;

— **Assignment to IRO.** If the Administrative Committee, or its delegate, determines that your request is eligible for an expedited external review, the Plan will assign an IRO and provide all necessary documents and information considered in its Adverse Benefit Determination to the IRO electronically or by telephone or facsimile or by any other available expeditious method; and

— **Notice.** The IRO will provide notice of its final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the initial notice of the final external review decision is not provided in writing, the IRO will provide written confirmation of the final external review decision to you and the Plan within 48 hours after the date of providing the initial notice.

**External Review for an HMO or Other Insured Program**

If you participate in an HMO (other than the Aetna HMO) or other insured program, your claim will be reviewed under the applicable Federal or a state external review program as follows:

Determination of Whether a Federal or a State External Review Procedure Is Applicable. If the applicable state law has an external review procedure that has been approved by the U.S. Department of Health and Human Services (“HHS”), that state’s external review procedure will apply to your claim. If the applicable state law does not have an external review procedure that has been approved by HHS as of the first day of the Plan Year, the Federal external review procedure will apply to your request for external review.

Your HMO or other carrier will advise you whether your state has an applicable qualified external review procedure or whether your claim will be subject to the Federal external review procedure. Your HMO or other carrier will also provide you a summary of the external review procedures that apply to you. The state and the Federal external review procedures for insured programs are substantially similar to the procedures that apply to Retiree Medical Program E – HDHP, Retiree
Medical Program E – CDHP 80, Retiree Medical Program E – CDHP 90, the Aetna HMO, Retiree Medical Program E – Indemnity and companion coverage under the Aetna and UHC Medicare Advantage Programs (as described above), although there are variations for each state’s procedures. The Federal external review procedures can be accessed online at [http://www.hhs.gov/cciio/regulations/interim_appeals_guidance_.pdf](http://www.hhs.gov/cciio/regulations/interim_appeals_guidance_.pdf) and are called “Technical Guidance For Internal Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review for Health Insurance Issuers in the Group and Individual Markets under the Patient Protection and Affordable Care Act.”

**Filing Fee for External Review**

If you request an external review, you may be required to pay to the Plan up to a $25.00 filing fee for each request. The fee will be waived if the Administrative Committee, or its delegate, determines that payment of the filing fee would impose an undue financial hardship upon you. The maximum limit on filing fees to be paid by you for any Plan Year (assuming you file three or more appeals in one Calendar Year) is $75.00. The filing fee will be refunded if the Adverse Benefit Determination or Final Adverse Benefit Determination is reversed through the external review. The $25.00 filing fee and the $75.00 maximum Plan Year limit on filing fees may be adjusted from time to time as determined by the Administrative Committee, or its delegate, in its sole discretion, subject to any limitations imposed by applicable law.

**Non-Benefit Claims**

**Enrollment and Eligibility Claims**

If you have questions regarding a program enrollment or eligibility claim (for example, if you missed an opportunity to add a Qualified Dependent to coverage as a result of a Qualified Change in Status event or if you dispute eligibility for the Retiree Medical Program), please contact the Prudential Benefits Center. You may contact the Prudential Benefits Center by calling [1-800-PRU-EASY](tel:1-800-PRU-EASY) (1-800-778-3279) and following the prompts for Health and Welfare benefits.

If you and the Prudential Benefits Center are not able to resolve your issue, the Prudential Benefits Center can provide you with a Claim Initiation Form. You may complete this form or submit written notice with the specific basis for your claim and send it to Claims and Appeals Management (CAM) at the following address:

Prudential Benefits Center  
Claims and Appeals Management (CAM)  
P.O. Box 1407  
Lincolnshire, IL 60069-1407

Your claim will be considered as soon as practicable following its receipt. Notice of an adverse determination shall be provided no later than 90 days after receipt of the claim. If the Prudential Benefits Center determines that special circumstances require an extension of time for processing the claim, written notice shall be furnished prior to the end of the 90-day period. Such extension shall not exceed 180 days after the date your claim was received.

If you have followed the above procedures and you receive an adverse determination, you may appeal the decision by following the steps described under “Appeal of an Adverse Determination of a Non-Benefit Claim” beginning on page 206. There is no right to an external review of the decision on appeal of a Non-Benefit Claim.

For all enrollment and eligibility claims, the Prudential Benefits Center is the Claims Administrator and the Administrative Committee is the Claims Fiduciary.

**Enrollment and Eligibility Claims for COBRA Coverage or COBRA-Like Coverage**

If you have questions regarding a program enrollment or eligibility claim (for example, if you dispute eligibility for continued Retiree Medical Program coverage) for COBRA coverage or for COBRA-like coverage (continued coverage for Domestic Partners or Extended Family Members that is similar to COBRA coverage [see “COBRA-Like Coverage for Qualified Adults” beginning on page 210 for more information]), please contact the Prudential Benefits Center, the COBRA administrator (effective as of
April 1, 2013, by calling **1-800-PRU-EASY (1-800-778-3279)** and following the prompts for Health and Welfare benefits and then COBRA.

If you and the Prudential Benefits Center are not able to resolve your issue, the Prudential Benefits Center can provide you with a **Claim Initiation Form**. You may complete this form or submit written notice with the specific basis for your claim and send it to Claims and Appeals Management (CAM) at the following address:

Prudential Benefits Center  
Claims and Appeals Management (CAM)  
P.O. Box 1407  
Lincolnshire, IL 60069-1407

Your claim will be considered as soon as practicable following its receipt. Notice of an adverse determination shall be provided no later than 90 days after receipt of the claim. If the Prudential Benefits Center determines that special circumstances require an extension of time for processing the claim, written notice shall be furnished prior to the end of the 90-day period. Such extension shall not exceed 180 days after the date your claim was received.

If you have followed the above procedures and you receive an adverse determination, you may appeal the decision by following the steps described under “Appeal of an Adverse Determination of a Non-Benefit Claim” beginning below. There is no right to an external review of a decision on a Non-Benefit Claim.

For all enrollment and eligibility claims for COBRA coverage or for COBRA-like coverage, the Prudential Benefits Center is the Claims Administrator and the Administrative Committee is the Claims Fiduciary.

**Other Non-Benefit Claims**

To make a claim under The Prudential Welfare Benefits Plan, other than for a claim for benefits (see “Claim for Benefits” beginning on page 197), or for enrollment and eligibility claims (see “Enrollment and Eligibility Claims” on page 205), you must send your request in writing to:

The Prudential Insurance Company of America  
The Prudential Welfare Benefits Plan Administrative Committee  
c/o Employee Benefits Department  
Prudential Plaza, 18th Floor  
751 Broad Street  
Newark, NJ 07102-3777

Your claim should state your name, address, the specific basis for your claim and any additional materials you wish to present.

Your claim will be considered by the Administrative Committee or its delegate as soon as practicable following its receipt. Notice of an adverse determination shall be provided no later than 90 days after receipt of the claim. If the Plan Administrator or its delegate determines that special circumstances require an extension of time for processing the claim, written notice shall be furnished prior to the end of the 90-day period. Such extension shall not exceed 180 days after the date your claim was received.

**Appeal of an Adverse Determination of a Non-Benefit Claim**

If you have followed the above procedures and you receive an adverse determination, you may appeal the decision by making a request in writing within 60 days after you receive notice of the adverse determination. Appeals must be sent to the Administrative Committee or its delegate, in this case the Appeals Committee, at the address in the “Other Non-Benefit Claims” section above.

Your appeal will be considered by the Appeals Committee as soon as practicable. Notice of an adverse determination of your appeal shall be provided no later than 60 days after receipt of the appeal. If the Appeals Committee determines that special circumstances require an extension of time for processing the appeal, written notice shall be furnished prior to the end of the 60-day period. Such extension shall not exceed 120 days after the date your request to appeal your adverse determination was received.
The Administrative Committee, as Plan Administrator, may appoint itself, one or more of its number, or any other person or persons whether or not connected with Prudential to review a claim. The ultimate decision of the Administrative Committee or its delegate shall be final and binding. Claims under the Plan will be granted only if the Plan Fiduciary or its delegate decides, in its sole discretion, that they should be granted. There is no right to an external review of a decision on appeal of a Non-Benefit Claim.

For more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

**Legal Action**

All the facts and circumstances of your case will be thoroughly reviewed. If you have completed all of the above claims, claims appeals and claims review procedures (see “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197) and your appeal and external review (if applicable) are given an Adverse Benefit Determination, you have the right to bring legal action if you believe the adverse determination is incorrect and was decided in an arbitrary and capricious manner. Any suit or legal action initiated by you must be brought by the earlier of (i) one year following a final decision on your claim, including any appeal or external review, or (ii) two years measured from the date your claim arose (except that this two-year limitation period will be suspended during the appeal and review of a claim under the Plan’s claims, claims appeals and external review procedures and except to the extent any policy or contract of an insurer provides a longer period of time to institute any suit or legal action). This time period for bringing a suit or legal action applies in all forums.

**Continuing Your Coverage**

**COBRA Coverage**

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (commonly known as COBRA), your Spouse and your Dependent Child(ren) who are covered under the Retiree Medical Program may elect to temporarily continue health care coverage under the Retiree Medical Program if their coverage ends because of a “Qualifying Event” as described in the section that follows. To be eligible for continued medical coverage, your Spouse and any Dependent Child(ren) must be enrolled in the Program when the coverage would otherwise end as a result of the Qualifying Event. In addition to your Spouse and any Dependent Child(ren) covered at the time of a Qualifying Event, any child who is born to your Spouse or Dependent Child(ren), adopted or placed for adoption with your Spouse or Dependent Child(ren) or any individual who marries your Spouse or Dependent Child(ren) during COBRA coverage is also eligible for coverage. The COBRA provisions in this section apply to any Retiree Medical Program, HMO, Medicare Advantage Program, Medicare Cost Program and companion coverage offered.

**Qualifying Events**

If coverage for your Spouse and/or your Dependent Child(ren) terminates due to any of the reasons in the table below, your Spouse and/or your Dependent Child(ren) may continue retiree medical coverage under COBRA.

As long as required premiums are paid in a timely manner, coverage can be continued as follows:

<table>
<thead>
<tr>
<th>If Coverage Under the Retiree Medical Program Stops Because:</th>
<th>The Maximum Continuation Period Is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You and your Spouse divorce or legally separate</td>
<td>36 months for your Spouse</td>
</tr>
<tr>
<td>Your Dependent Child(ren) no longer qualify</td>
<td>36 months for your Dependent Child(ren)</td>
</tr>
</tbody>
</table>

**Please note**: If you choose to disenroll a Qualified Dependent from coverage at any time, including during the Annual Enrollment Period, the Qualified Dependent will not experience a Qualifying Event or become eligible to elect COBRA continuation coverage.
Notification

Upon Experience of a Qualifying Event

If your Spouse and/or your Dependent Child(ren) experience any of the Qualifying Events (as previously described), you, your Spouse and/or your Dependent Child(ren) must notify the Prudential Benefits Center in order to qualify for COBRA continuation coverage. You, your Spouse and/or your Dependent Child(ren) must notify the Prudential Benefits Center within 60 days of the later of the Qualifying Event or the date that benefits would be terminated under the Program as a result of the Qualifying Event. To notify the Prudential Benefits Center, call 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Your Spouse and/or your Dependent Child(ren) then will be provided with a notice of rights to continue medical coverage and instructions. (See “How to Purchase Continued Medical Coverage” on page 209 for more information.)

If Your Spouse and/or Your Dependent Child(ren) Are Already on COBRA

You, your Spouse and/or your Dependent Child(ren) must notify the Prudential Benefits Center, the COBRA administrator, if your Spouse and/or your Dependent Child(ren) are already on COBRA and experience any of the following events:

• You and your Spouse divorce or legally separate; or

• Your Dependent Child(ren) no longer qualify.

You, your Spouse and/or your Dependent Child(ren) must notify the COBRA administrator within 31 days of the later of the Qualifying Event or the date that benefits would be terminated under the Program as a result of the Qualifying Event. To notify the Prudential Benefits Center, call 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits and then COBRA.

If You Die While a Retiree Medical Program Participant

In the event of your death, your Spouse and/or your Dependent Child(ren) may continue coverage under the Retiree Medical Program as long as they continue to qualify as a Surviving Dependent. Generally, coverage will continue automatically for your surviving Spouse and/or Dependent Child(ren). However, they may need to change to a different Retiree Medical Program option if they are no longer eligible for the specific option they had before your death. Eligibility will depend on your Surviving Dependent’s eligibility for Medicare and your Benefits Eligibility Date. The Prudential Benefits Center will notify your Spouse and/or your Dependent Child(ren) of their eligibility to continue coverage and their options for coverage. (See “How Medicare Affects Your Retiree Medical Program Options” on page 186 for more information.)

Your surviving Spouse and Dependent Child(ren) will not be required to elect COBRA continuation coverage at this time, nor will they be required to pay the COBRA rates discussed in the section that follows. If your Spouse and/or Dependent Child(ren) become ineligible for this Retiree Medical Program coverage (for example, if your Spouse remarries or your Dependent Children cease to be Dependents) before the end of the 36-month period following your death, your Spouse and/or Dependent Child(ren) must notify the Prudential Benefits Center within 60 days of the later of the Qualifying Event or the date that benefits would be terminated under the Program as a result of the Qualifying Event in order to qualify for COBRA continuation coverage. If they provide timely notification, they will be entitled to elect COBRA continuation coverage for the remaining portion of the 36-month period following your death.

If you have the RMSA for financial support, the remaining balance in the RMSA will become a new account created for your Spouse (or your oldest Dependent Child if you have no Spouse) so that your eligible Spouse and Dependent Child(ren) may continue to use the RMSA to be reimbursed for their eligible health care premiums (or unreimbursed premiums for you incurred prior to your death). If you have no Spouse or Dependent Child, your account is forfeited at your death. However, your estate will have up to one year after your death to submit eligible claims for reimbursement from your RMSA. If you have listed a Qualified Adult as an eligible dependent under the RMSA, your Qualified Adult will
no longer have access to the RMSA and can no longer receive reimbursement from the RMSA for eligible expenses in the event of your death.

For more information, call the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and follow the prompts for Health and Welfare benefits.

**How to Purchase Continued Medical Coverage**

If your Spouse and/or your Dependent Child(ren) become eligible for coverage under the COBRA continuation provision (either because of divorce/legal separation or the Dependent Child ceasing to be a Dependent), the COBRA administrator will send your Spouse or your Dependent Child(ren):

- A notice of the right to continue coverage;
- Information on the Cost of continuing coverage; and
- Information about electing continued coverage.

To elect continuation of coverage, COBRA elections must be made on the Prudential Benefits Center website or by calling the Prudential Benefits Center within 60 days after the later of the following dates:

- The date on the notice of the right to continue coverage; or
- The date the Program coverage ends.

An additional 45-day period is available to pay the initial premium from the date of your COBRA election.

**Premium Due Date**

If your Spouse or Dependent Child(ren) elect COBRA continuation coverage for the Retiree Medical Program, your Spouse or Dependent Child(ren) must pay the initial premium within 45 days of the date of the COBRA election. The invoice will indicate the amount of the first payment. Thereafter, COBRA premiums must be paid monthly and within 30 days after the date each one is due. If payment is not received in a timely manner, coverage will be terminated retroactively to the last day for which timely payment was made.

**Paying for Coverage**

Coverage can be paid monthly by submitting payment to the Prudential Benefits Center or by using the Pay Now feature on the Prudential Benefits Center website to process a one-time bank payment from a checking or savings account. Your Spouse or Dependent Child(ren) can also take advantage of direct debit with the Prudential Benefits Center and have automatic deductions from a checking or savings account. If direct debit is chosen, all future payments will be taken from the account on the first of the month. To make a payment, access the Prudential Benefits Center website or call the Prudential Benefits Center.

**Cost**

For continuing coverage under the Retiree Medical Program, the Cost of COBRA continuation coverage is 102% of the full Cost of Program coverage.

**Coverage During the Continuation Period**

If coverage under the Retiree Medical Program is changed, the same changes will apply to individuals on COBRA continuation. Your Spouse and/or your Dependent Child(ren) also may change coverage elections during Annual Enrollment Periods, if a Qualified Change in Status occurs (see “Qualified Change in Status” beginning on page 27 for more information), or at other times under the Program to the same extent that similarly situated non-COBRA participants may do so.

**When COBRA Coverage Ends**

COBRA continuation of medical coverage for any person will end when the first of the following occurs:
• The applicable continuation period ends;

• The initial premium for continued coverage is not paid within 45 days after the date COBRA is elected, or any subsequent premium is not paid within 30 days after it is due;

• After the date COBRA is elected, your Spouse and/or your Dependent Child(ren) first become covered (as a retiree or otherwise) under another group health plan not offered by the Company that:
  — Does not contain an exclusion or limitation affecting the person’s preexisting condition; or
  — The other plan’s preexisting condition limit or exclusion does not apply or is satisfied because of HIPAA;

• After the date COBRA is elected, your Spouse and/or your Dependent Child(ren) first become entitled to Medicare. Your Spouse and/or your Dependent Child(ren) must notify the Prudential Benefits Center upon becoming entitled to Medicare. See the “Notification” section that follows for more information. This does not apply to your Spouse and/or your Dependent Child(ren) who are not entitled to Medicare;

• For newborns and children adopted by or placed for adoption with your Spouse and/or your Dependent Child(ren) during their COBRA continuation period, the date your Spouse’s and/or your Dependent Child(ren)’s COBRA continuation period ends; or

• The Company terminates all medical coverage under the Retiree Medical Program.

**Notification**

If your Qualified Dependent no longer qualifies for COBRA coverage (for example, if your Spouse and/or your Dependent Child(ren) become covered under another medical program), you must notify the Prudential Benefits Center by calling **1-800-PRU-EASY (1-800-778-3279)** and following the prompts for Health and Welfare benefits and then COBRA.

**COBRA-Like Coverage for Qualified Adults**

While COBRA coverage applies only to your Spouse and your Dependent Children, Prudential will make available (within a specified timeframe) continued medical coverage similar to COBRA coverage for a Qualified Adult (a Domestic Partner or an Extended Family Member) for a defined period of time if:

• Your Domestic Partner or Extended Family Member no longer meets the eligibility requirements under the Retiree Medical Program;

• You no longer meet the eligibility requirements under the Retiree Medical Program; or

• You die.

Not all the Programs under the Retiree Medical Program allow COBRA-like coverage for a Domestic Partner or an Extended Family Member. It is your responsibility to contact your carrier to verify what type of continuation coverage is available, if any.

To be eligible for COBRA-like coverage, you must be covering your Domestic Partner or Extended Family Member under the Retiree Medical Program at the time of the Qualifying Event listed under “Qualifying Events” on page 207.

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13 For COBRA purposes, entitlement to Medicare means being enrolled in Medicare Parts A and/or B.
The Cost of the COBRA-like coverage for your Domestic Partner or Extended Family Member will be the same as the COBRA Cost. Premiums will be made on an After-Tax basis and will equal 100% of the group Cost, plus an additional 2% for administrative Costs.

If you die while covering your Domestic Partner or Extended Family Member under the Retiree Medical Program, your Domestic Partner or Extended Family Member may continue the COBRA-like coverage for up to 36 months.

**Continued Coverage of the RMSA (for Retirees Only)**

During your retirement there are two situations—divorce and a Dependent Child losing eligibility—that are considered COBRA Qualifying Events if you are enrolled in the RMSA. If either of these events occurs, the individual losing access to the RMSA is eligible to enroll for the RMSA through COBRA continuation coverage. It is your responsibility to make sure these situations are reported to the Prudential Benefits Center within 60 days of the date of the loss of coverage in order for your Dependents to be eligible for COBRA.

See “The Retiree Medical Savings Account (RMSA)” section beginning on page 8 for more information.

**If You Divorce**

If you and your Spouse divorce after retirement, you must report the divorce to the Prudential Benefits Center by calling 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare Benefits when the divorce occurs.

Prudential Benefits Center Representatives will instruct you on how to proceed at that point. Your ex-Spouse and/or any Dependent Children who lose access to the RMSA will then be offered RMSA COBRA continuation coverage.

**If a Dependent Child Is No Longer Eligible**

When a Dependent Child ceases to be a Dependent under the terms of the Retiree Medical Program, he/she is no longer eligible to have premiums reimbursed from the RMSA. Since that Dependent Child is losing coverage, he/she is entitled to RMSA COBRA continuation coverage. You will need to notify the Prudential Benefits Center by calling 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits within 60 days to report the loss of coverage.

Prudential Benefits Center Representatives will instruct you on how to proceed. Your Dependent Child who loses access to the RMSA will then be offered RMSA COBRA continuation coverage.

**Health Insurance Marketplaces**

Health Insurance Marketplaces (also referred to as “Exchanges”) have been established in each state to help people purchase individual health insurance coverage—particularly for those without access to affordable, employer-sponsored health coverage. Enrollment in an Exchange is available as an alternative to continuation of coverage through COBRA or COBRA-like coverage.

Depending on the Medicare status of your Dependent(s), the Health Insurance Marketplace will mean different things for them:

- If your Dependents are Medicare-eligible (generally, those age 65 and older): The Health Insurance Marketplace is probably not relevant to them. There are already a number of options to supplement or enhance their Medicare coverage, which you can learn more about by visiting the Medicare website (at [www.medicare.gov](http://www.medicare.gov)); or

- If your Dependents are not eligible for Medicare (generally, those under age 65): They may want to determine whether they qualify for a premium tax credit. Visit [www.healthcare.gov](http://www.healthcare.gov) for information about tax credits. If they do qualify, their premiums for Health Insurance Marketplace coverage would be offset by the tax credit. They may want to compare the costs and benefits of Prudential-sponsored coverage options against that of the offerings through their state’s Health Insurance Marketplace.

Visit [www.healthcare.gov](http://www.healthcare.gov) if you have questions about the Health Insurance Marketplaces.
Your Rights

As a participant in The Prudential Welfare Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA).

ERISA provides that all ERISA-governed plan participants shall be entitled to:

- Receive information about the Plan, including:
  
  — Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all documents governing the Plan. This includes insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by The Prudential Welfare Benefits Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
  
  — Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and the updated Summary Plan Description. The Plan Administrator may make reasonable charges for the copies; and
  
  — 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 Retiree Medical Program coverage:
  
  — Continue medical coverage if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Qualified Dependents may have to pay for such coverage. Review this Retiree Medical Program SPD booklet and the documents governing the Retiree Medical Program on the rules governing your COBRA continuation coverage rights. (See “Continuing Your Coverage” beginning on page 207 for more information); and
  
  — Reduce or eliminate exclusionary periods of coverage for preexisting conditions under your medical program, if you have creditable coverage from another medical program. You should be provided a certificate of creditable coverage, free of charge, from your medical program or health insurance issuer when you lose coverage under the program, 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.

- Enforce your rights:

  If your claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

  Under ERISA, there are steps you can take to enforce the above rights. For instance:

  — If you request a copy of the Plan Document or the latest annual report from the Plan Administrator and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator;

  — If you have a claim for benefits that is denied (or ignored), in whole or in part, you may file suit in a state or Federal court, after you complete (or if your claim is ignored, have attempted to complete) all of the claims and appeals procedures. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197);
If you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order (QMCSO), you may file suit in Federal court, after you complete all of the claims and appeals procedures. (See “Assignment of Benefits” on page 196 and “Qualified Medical Child Support Order” on page 197, and “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information); and

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, after you complete all of the claims and appeals procedures. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197.)

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 to be frivolous.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for The Prudential Welfare Benefits Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Retiree benefit plans. The people who operate The Prudential Welfare Benefits Plan, called “Fiduciaries” of the Plan, have a duty to do so prudently and in the interests of all participants and Qualified Dependents. No one, including your employer, your union (if applicable), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Recovery of Benefits if Payable by a Third Party

Benefits otherwise payable to you (i.e., the participant Employee or your Covered Qualified Dependent) under The Prudential Welfare Benefits Plan (the “Plan”) will be reduced to the extent that payment is made directly or indirectly to you or on your behalf, or to your assignee, by any third party or its insurer. This could occur as the result of the actual or alleged wrongful act or omission of any third party (for example, an automobile accident) or a payment made or to be paid from your own no-fault and automobile insurance policy(ies) (i.e., uninsured motorist coverage, underinsured motorist coverage, medical payments coverage [“Med Pay”], no-fault coverage, and/or personal injury coverage [“PIP”]). (See “Non-Duplication of Benefits Provision” beginning on page 183 and “Non-Duplication of Benefits in Accidents” on page 184 for more information.)

Please note: You should review your automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. The Plan always pays secondary to any motor vehicle policy including any medical payments, PIP or no fault coverage available to you.

If the Retiree Medical Program under the Plan provides benefits to you, or your Covered Qualified Dependent, that are later determined to be the legal responsibility of another person company or insurer, the Plan has a first priority right to recover these payments from you or your Covered Qualified Dependent in full and regardless of whether you have been made whole.

If you make a claim for benefits before you receive payment from any third party or its insurer, you are considered by the Plan to have agreed that any recovery you receive from any third party or its insurer will be used to repay the Plan for its payments on your behalf. The Plan’s right to recovery applies whether:

• You receive payment due to a legal judgment, an arbitration award, a compromise settlement or any other arrangement;

• Any third party or its insurer admits liability for the payment; or

• The expenses the Plan paid are separately identified or otherwise itemized in the payment made to you by the third party or its insurer.
You should know that an assignment of your claim to any third party does not exempt you from your responsibility for repayment. In order to secure the Plan’s recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan’s subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim. Any attorney fees or costs incurred by you are not the responsibility of the Plan and are to be paid solely by you. The Plan is entitled to its share of recovery even if you do not recover full damages claimed.

**You Must Give Notice.** Within ten days of institution of any legal proceedings on your behalf against any third party or its insurer for recovery of any amount that otherwise would be payable to the Plan under this section, you must notify the Plan of the legal proceedings, including the names of the parties, the name and location of the forum, the status of the case, the names, addresses and phone numbers of all attorneys and the case number. You must also, within 30 days prior to any settlement of any legal proceedings against the third party or its insurer, notify the Plan of the terms of the proposed settlement.

**The Plan’s Legal Rights.** By accepting payment from the Plan of medical benefits, you are deemed to have agreed that the Plan may take all action necessary or appropriate in the discretion of the Administrative Committee or its delegate to enforce its rights under this section. Such action includes, but is not limited to:

- **Subrogation:** The Plan is subrogated to (stands in the place of) all rights of recovery you or your Covered Qualified Dependent have against any third party or insurer for all or any portion of the benefits provided or to be provided by the Plan.

- **Reimbursement:** In addition, if you or a Covered Qualified Dependent receives any payment from any third party or insurer, the Plan has the right to obtain reimbursement from you, your attorney or any third party, for all amounts the Plan has paid and will pay, up to and including the full amount you receive.

- **Constructive Trust:** The Plan has a right to obtain a legal order that you, your attorney, or anyone acting on your behalf is considered to hold any amount you recover from any third party or insurer for benefits provided or to be provided under the Plan in a constructive trust for the benefit of the Plan.

- **Lien Rights:** Further, the Plan will automatically have an equitable lien to the extent of benefits paid by the Plan for which any third party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise, including from any insurance coverage, for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to you or your representative or agent; any third party or insurer; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

- **Stay or Other Equitable Relief:** The Plan has a right to obtain a stay of any legal proceedings brought by you or your Covered Qualified Dependent against any third party and to enjoin you and your assignees from adjudicating the matter. It also may obtain a preliminary or permanent injunction, a declaration of rights, or specific performance against you, your attorney, or any assignee of either of them. Moreover, the Plan has the right to obtain any other appropriate equitable relief to redress any violation of the Plan or enforce the terms of the Plan. The Plan also has the right to obtain such judicial relief against you or any assignee as may be available under state law, including a claim for breach of contract.

**Applicability to All Settlements and Judgments.** The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any third party or insurer and regardless of whether the settlement or judgment received by you identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to the payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages.
Cooperation. You and your Covered Qualified Dependents are prohibited from prejudicing the Plan’s subrogation or recovery interest or prejudicing the Plan’s ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude any portion of the cost of any benefits provided by the Plan. The Plan has the right to conduct an investigation regarding the injury, illness or condition for which benefits were provided under the Plan to identify any third party or insurer responsible for the payment of all or any portion of those benefits. The Plan reserves the right to notify the third party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Written Agreement to Repay. The Plan may require you to sign a written agreement to repay any amounts received by you in the event you recover such amounts from any third party or its insurer, including establishing a trust or lien on any monies you are to receive.

Failure to Comply. If you fail to timely provide the notice required under this section or refuse to execute any agreement, if requested to do so, no further benefits will be paid on your behalf under the Plan until the Plan either recovers all amounts you are required to repay or offsets against your future benefits payable under the Plan, any payments made by the Plan that it was unable to recover. In the sole discretion of the Administrative Committee or its delegate, any action by you to frustrate or avoid recovery by the Plan, as required by this section may be grounds for termination of all your benefits under the Plan.

Interpretation. In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Administrative Committee or its delegate has the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction. By accepting benefits (whether the payment of such benefits is made to you or your Covered Qualified Dependent or made on your behalf to any provider) from the Plan, you and your Covered Qualified Dependent agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you and your Covered Qualified Dependent hereby submit to each such jurisdiction, waiving whatever rights you and your Covered Qualified Dependent may have by reason of his/her present or future domicile.

Recovery of Overpayment

If the Retiree Medical Program provides benefits to you or a Covered Qualified Dependent that are later determined to be in excess of the covered amounts, the Retiree Medical Program has the right to recover these payments from you. You should know that an assignment of your claim to any third party does not exempt you from your responsibility for repayment of overpayments.

Protecting Your Personal Health Information: HIPAA Privacy

Prudential’s health care programs are subject to the privacy regulations issued by the Department of Health and Human Services (HHS) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (“Privacy Regulations”) and will protect your confidential health information. Prudential’s Group Health Plans maintain a HIPAA Notice of Privacy Practices, which describes your rights and the Plan’s responsibilities under the Privacy Regulations. To obtain a copy of the notice, visit the Prudential Benefits Center website (at www.prubenefitscenter.com). If you do not have access to a computer or the Internet or if you need more information, you may contact the Prudential Benefits Center by calling 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.

The Privacy Regulations were enacted to guarantee participants new rights and protection against the misuse or disclosure of their personal health information. The regulations require most health plans to provide notice of how personal health information may be used and what rights you have regarding this information. This notice must be provided before using or disclosing your health information to carry out treatment, payment or health care operations. The protection extends to information in any form, including electronic and paper records and spoken words.
If you feel that your privacy protection rights have been violated, you can file formal complaints against the health care plan with HHS.

For more information about Privacy Regulations, visit the HHS website (at www.hhs.gov).

**Assistance with Your Questions**

If you have any questions about The Prudential Welfare Benefits Plan, you should contact the Prudential Benefits Center. 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 Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or contact:

Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration  
U.S. Department of Labor  
200 Constitution Avenue, N.W.  
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration at 1-866-444-3272.

**If You Do Not Have Access to the Prudential Benefits Center Website**

Throughout this SPD booklet there are references to accessing the Prudential Benefits Center website (at www.prubenefitscenter.com). If you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

**Service of Legal Process**

Most questions about the Retiree Medical Program benefits may be resolved by calling the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits, or by completing the claims and appeals process. (See “Claims, Claims Appeals and External Claims Review Procedures” beginning on page 197 for more information about this process.) However, if, after you have completed all of the claims and appeals procedures described in this Retiree Medical Program SPD booklet, you feel you need to take legal action to resolve a question governing your benefits or your claim, then you may contact the agent for service of legal process in a timely manner at the following address:

The Prudential Insurance Company of America  
Vice President for Employee Benefits  
Employee Benefits Department  
Prudential Plaza, 18th Floor  
751 Broad Street  
Newark, NJ 07102-3777  
Telephone: 1-973-802-6000

Legal papers may also be served in a timely manner on The Prudential Welfare Benefits Plan Administrative Committee or the respective Plan Trustee, if any. Any suit or legal action must be brought by you no later than one year following a final decision on your claim for benefits.
Glossary

In this section, you will find definitions for some of the terms used in this SPD booklet. If you need more help understanding a certain term, call the Prudential Benefits Center at **1-800-PRU-EASY (1-800-778-3279)** and follow the prompts for Health and Welfare benefits.

The Prudential Retiree Welfare Benefits Plan was established by the Company effective January 1, 2014, to provide various retiree health and welfare benefits previously provided by The Prudential Welfare Benefits Plan. Specifically, Retiree Medical Program benefits are provided under The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All references to The Prudential Welfare Benefits Plan in this SPD booklet should be read to refer to The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All other terms, conditions, limitations and exclusions of this SPD booklet are hereby incorporated and form the summary plan description for The Prudential Retiree Welfare Benefits Plan.

**Adverse Benefit Determination**
An Adverse Benefit Determination is any denial, reduction, or termination of a benefit, or a failure to provide or make a payment. You have the right to appeal any Adverse Benefit Determination under the claims and appeals procedures described in this SPD booklet.

**After-Tax**
After-Tax basis, contributions or dollars means that a portion of your income is deducted from your pay after any applicable Federal, state and local income taxes and Social Security taxes have been withheld and contributed by you to a plan or program or used to pay all or a portion of the Cost of coverage for certain plans or programs. Your deducted pay will still be part of your taxable income.

**Agency Distribution Financial Professional**
An Agency Distribution Financial Professional is a full-time life insurance salesman as defined under Internal Revenue Code Section 3121(d)(3)(B) and the regulations prescribed thereunder, including an associate under any of the following contracts: Senior Life Representative, Statutory Agent Agreement or Career Special Agent.

**Agency Distribution Financial Professional Associate**
An Agency Distribution Financial Professional Associate is a common law Employee participating in a two-year developmental program within Agency Distribution.

**Annual Enrollment Period**
The Annual Enrollment Period is your opportunity to review your current benefits coverages and then re-enroll or make desired changes for the next Calendar Year, without restrictions that might otherwise apply. For Retiree Medical Program coverage, you may make changes during the Annual Enrollment Period or if you have a Qualified Change in Status. Start and end dates of the Annual Enrollment Period are announced each year by the Administrative Committee.

**Annual Out-of-Pocket Maximum**
The maximum amount you and your Covered Qualified Dependents can pay each Calendar Year out of your own pocket toward Covered Expenses. It includes your annual Deductible and all expenses subject to Coinsurance. Once you reach the Annual Out-of-Pocket Maximum, the program will pay 100% of Covered Expenses up to the Reasonable and Customary (R&C) Fees or Negotiated Fees for the remainder of that Calendar Year.

There are exceptions to the 100% coverage:

- Under the Aetna HMO, Prescription Drug charges continue to be covered as described under “The Retiree Prescription Drug Program” section beginning on page 31. In addition, for claims incurred during the 2013 Plan Year, you were responsible for paying Copays even after the Annual Out-of-Pocket Maximum was met. Effective January 1, 2014, the Annual-Out-of-Pocket Maximum also includes Copays.
• Under the CDHP 80, the CDHP 90 and Retiree Medical Program E – Indemnity, Prescription Drug charges continue to be covered as described under “The Retiree Prescription Drug Program” section beginning on page 31.

Benefits Eligibility Date
The Retiree Medical Program options available to benefits-eligible individuals are based on your Medicare eligibility and your Benefits Eligibility Date (and in some cases, where you live). To determine your Benefits Eligibility Date, please note:

• Retirees: Your Benefits Eligibility Date is your retirement date (the first day following your last day of employment). If you became a Retiree because you reached the maximum duration of benefits under the Long Term Disability Program, your Benefits Eligibility Date will continue to be the date you commenced benefits under the Long Term Disability Program;

• Long Term Disability Participants: Your Benefits Eligibility Date is the date you commenced benefits under the Long Term Disability Program; or

• Surviving Dependents: If the Employee upon whose service your benefits are based died before retirement, your Benefits Eligibility Date is the date of that Employee’s death. If that Employee died after retirement or commencement of Long Term Disability, your Benefits Eligibility Date is that Employee’s retirement date or date of commencement of Long Term Disability.

Brand-Name Drug
A Brand-Name Drug is a medication owned and manufactured by a single pharmaceutical company under a proprietary name. A Brand-Name Drug is protected by an exclusive patent.

Brand-Name Non-Preferred Drug
A Brand-Name Drug that is not included on Express Scripts’ National Preferred Formulary. (This does not apply for local HMOs; contact your local HMO for details.)

Brand-Name Preferred Drug
A Brand-Name Drug that is included on Express Scripts' National Preferred Formulary. (This does not apply for local HMOs; contact your local HMO for details.)

Calendar Year
A Calendar Year begins January 1 and ends December 31.

Centers/Institutes of Excellence
Centers/Institutes of Excellence are medical facilities and staff who are experienced in specialty procedures, such as organ and tissue transplants, cardiac by-pass surgery, angioplasty and brain/spinal cord surgeries. Centers/Institutes of Excellence contract for the cost-effective performance of high-risk and/or high-cost procedures.

Claims Administrator
The entity designated to handle the requests for payment of benefits under the various plans and programs. In some instances, this entity may also be designated to handle appeals for denied benefits. The Claims Administrators for the different Retiree Medical Program options are listed in this SPD booklet. (See “Insurance Issuers and Administrators” beginning on page 191.) Please note that the Claims Administrator for program enrollment and eligibility claims is the Prudential Benefits Center and the Administrative Committee or its delegate is the Claims Fiduciary. As of April 1, 2013, the Prudential Benefits Center is the Claims Administrator for COBRA enrollment and eligibility claims and the Administrative Committee is the Claims Fiduciary for COBRA.

Claims Fiduciary
The Fiduciary for all actions involving the payment of benefits under an ERISA plan. The Administrative Committee or its delegate is the Claims Fiduciary for the Retiree Medical Program and COBRA, including for program enrollment, eligibility and Non-Benefit Claims.
COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985, as amended)
The Federal law under which you and/or your Covered Qualified Dependent(s) may be able to extend your Retiree Medical Program coverage after the time such coverage or participation normally would end.

Coinsurance
Coinsurance is a provision by which you share in the cost of Covered Services on a percentage basis after you pay any required annual Deductibles. For example, in the Out-of-Network portion of the CDHP 90, the Coinsurance arrangement is 70%/30%. This means the Program pays 70% and you pay 30% of any eligible charges.

Company
The Prudential Insurance Company of America.

Concurrent Care Claim
A Concurrent Care Claim means any preauthorized health claim that is for an ongoing course of treatment.

Coordination of Benefits
If you are covered under another Prescription Drug program (for example, if your Spouse has coverage under his/her employer plan, and you are covering your Spouse under your program), that program’s benefits will be coordinated with the benefits provided under the Retiree Prescription Drug Program or Prescription Drug benefits provided under the HDHP. Together, the two programs will pay up to a maximum of 100% of allowable expenses. This provision is called “Coordination of Benefits,” and it applies to Prescription Drug coverage only.

Copay
The flat dollar amount that you pay each time you receive covered treatment, services or supplies is called a Copay. With Copays, the amount you pay does not vary with the cost of the service.

Cosmetic Surgery
Services or supplies that alter, improve or enhance appearance.

Cost
Cost of benefits or coverages refers to the charges determined by Prudential, using the best tools available, to estimate the total amount that will be expended for your benefits during the Calendar Year. If the program is self-insured (rather than provided through an actual insurance policy with a premium), the actual expenditures for the Calendar Year may be higher or lower than the determined charge, depending on the Calendar Year.

Any amount charged to a participant will be based solely on the original estimated charge, not the actual expenditures. Depending on the benefit, this Cost may be borne by the participant directly; by Prudential directly or indirectly from a Plan fund, such as a Contractual Special Reserve (CSR), established with contributions from Prudential; or by a combination of these sources.

Covered Charges
Covered Charges are the expenses that the Retiree Medical Program options will cover in part or in full, up to the Negotiated Fee for Participating Providers, or up to the Reasonable and Customary (R&C) Fee for a Medically Necessary service charged by Out-of-Network providers.

Covered Expenses
Covered Expenses are the expenses that the Retiree Medical Program options will cover in part or in full, up to the Negotiated Fee for Participating Providers, or up to the Reasonable and Customary (R&C) Fee for a Medically Necessary service charged by Out-of-Network providers.
Covered Services
Covered Services are those services that are Medically Necessary, as defined in this Glossary for which the Program will make benefit payments or apply to the annual Deductible, if applicable.

Credit Approach
A method by which Prudential currently provides financial support for Retiree medical coverage for all eligible Employees who retired on or after January 1, 2001, and prior to January 1, 2011. Employees retiring in 2008, 2009 and 2010 had a one-time irrevocable choice between the Credit Approach and the Retiree Medical Savings Account. Under the Credit Approach, Prudential provides an annual credit toward the cost of Retiree medical coverage to Retirees when they Retire. This annual credit amount has not increased since 2008, will not increase in the future and cannot be used for Prudential dental or vision coverage, non-Prudential coverage or Medicare coverage. The only time the annual credit amount will change is when you or your Spouse becomes eligible for Medicare.

Cross-Apply/Applies
A benefit Cross-Applies when the number of visits or the dollar maximum allowed accumulates to both In-Network and Out-of-Network benefits.

Custodial Care
Custodial Care is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered.

Custodial Care is not covered under the Retiree Medical Program.

Deductible
A Deductible is the amount you must pay out of your own pocket for yourself and/or your Covered Qualified Dependents each Calendar Year before the program starts paying benefits. Two types of annual Deductibles may apply:

- **Individual Deductible**: The out-of-pocket amount payable toward Eligible Expenses for one covered person before the program starts paying benefits; and

- **Family Deductible**: The combined out-of-pocket amount payable toward Eligible Expenses for more than one covered person before the program starts paying benefits.

Dependent (Covered Qualified Dependent)
A Dependent is a Spouse or other family member that you may choose to cover under the Program. Different terms can be used to describe a Dependent:

- A Qualified Dependent is a person who meets the eligibility requirements for coverage under the Program.

- A Covered Qualified Dependent is one whom you have actually enrolled for coverage under the Program.

Dependent Child(ren)
- Your Dependent Children\(^{14}\) are:
  - Your natural children under age 26;

\(^{14}\)Some local HMOs may have different eligibility requirements for Dependent Children. Call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits. Dependent Children are only eligible for medical coverage under a Medicare Advantage Program or Medicare Cost Program if they are Medicare-eligible.
— Your adopted children under age 26;

— Children under age 26 placed with you for adoption;

— Children under age 19 who are living in your home for whom you are the legal guardian and for whom you receive no monetary compensation from a state or county agency;

— A child living in your home for whom you are the legal guardian continues to qualify between the ages of 19 and 26 if the child:
  - For the period between the ages of 19 and 24 is a full-time student at an Educational Institution;
  - Is Substantially Dependent on you; and
  - Participated in the Prudential Medical Program or Retiree Medical Program at the time the child attained age 19.

Coverage is continued without regard to whether you continue to have legal responsibility under an order of guardianship;

— Your stepchildren under age 26;

— Your unmarried grandchildren under age 19 when:
  - Your child—the parent or stepparent (who has legal custody) of the grandchild—meets the definition of a Dependent Child, and is covered under the Program (your child cannot be covered as an Extended Family Member if the grandchild is to be covered as a Dependent Child);
  - Your grandchild qualifies as a “Qualifying Child” (as defined beginning on page 233) or “Qualifying Relative” (as defined on page 234) under the Internal Revenue Code (the “Code”); and
  - Your grandchild is living in your household or is a full-time student at an Educational Institution;

— Your unmarried grandchild living in your home for whom you are the legal guardian (as previously described) continues to qualify between the ages of 19 and 26 if the grandchild:
  - For the period between the ages of 19 and 24 is a full-time student at an Educational Institution;
  - Is Substantially Dependent on you; and
  - Participated in the Prudential Medical Program or Retiree Medical Program at the time the grandchild attained age 19.

Coverage is continued without regard to whether:
  - Your unmarried Dependent Child continues to have legal custody of your grandchild; or
  - The grandchild continues to live in your home;

— Your unmarried Dependent Children (as previously described) age 26 or older who are incapable of sustaining self-supporting employment due to a mental or physical disability, if:
− Such children participated in the Prudential Medical Program or Retiree Medical Program at the time they attained age 26 (this must be a continuation of coverage that was in effect prior to exceeding the above age limit);

− The children participated in a different medical program at the time they attained age 26 and remained continuously covered until the loss of that other coverage and the children became participants within 31 days of the loss of the other coverage; or

− At the time of your marriage, your Spouse’s child was already disabled and over age 26 and such child became a participant within 31 days of the date of your marriage.

For a Dependent Child meeting this definition, you may continue that child’s coverage as long as your child remains continuously covered, is Substantially Dependent on you, the child remains incapacitated and unmarried and the child qualifies as a “Qualifying Child” (as defined beginning on page 233) or as a “Qualifying Relative” (as defined on page 234).

If you wish to enroll a Dependent Child who meets this definition, you may do so by calling the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.

You will be required to furnish medical evidence of the Dependent Child’s disability upon request from your medical program carrier; and

− Any child required to be covered under either a Qualified Medical Child Support Order or a National Medical Support Notice (without regard to whether such child is a “Qualifying Child” or a “Qualifying Relative”).

Coverage for a Dependent Child who reaches age 26 and is not incapable of sustaining self-supporting employment due to a mental or physical disability will be terminated at the end of the month during which the Dependent Child reaches age 26.

*Your Child Age 26 or Older, a Child Living in Your Home for Whom You Are the Legal Guardian and Your Grandchild Must Be Your “Qualifying Child” or Your “Qualifying Relative”*

Except in the case of a child required to be covered under a Qualified Medical Child Support Order or a National Medical Support Notice, your Dependent Child age 26 or older, a Child living in your home for whom you are the legal guardian and your grandchild must, in order to satisfy the definition above, qualify and continue to qualify as either your “Qualifying Child” or “Qualifying Relative.”

See the definitions of “Qualifying Child” beginning on page 233 and “Qualifying Relative” on page 234 for more information.

**Domestic Partner**

To meet Qualified Adult eligibility requirements for a program, your same-sex or opposite-sex Domestic Partner must:

− Be age 18 or older;

− Have lived with you for at least six months and remain a member of your household during the period of coverage;

− Be and have been in a serious and committed relationship with you for at least six months;

− Be Financially Interdependent with you;

− Not be related to you in any way that would prohibit legal marriage (laws vary from state to state); and

− Not be legally married to, or a Domestic Partner of, anyone else.
To enroll your Domestic Partner, you must follow the Domestic Partner certification process on the Prudential Benefits Center website (at www.prubenefitscenter.com), or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Educational Institution
An institution that maintains a regular faculty and curriculum, including primary and secondary schools, colleges, universities and technical and mechanical schools. The term does not include non-educational institutions, on-the-job-training schools and correspondence schools.

Eligible Expenses
Charges incurred by an eligible Employee or Qualified Dependent, which are eligible for reimbursement under the Program.

Emergency
A medical Emergency is a sudden and urgent illness or injury that could be life-threatening or seriously harm bodily function if not treated immediately.

Employee
Generally, any person who is categorized as an Employee on the books and records of the Company or any affiliate, or is compensated as an Agency Distribution Financial Professional by the Company or any affiliate, will be considered an Employee for the purposes of this Plan. The term “Employee” never includes any individual who is associated with the Company or any affiliate as:

- An Agency Distribution Financial Professional Emeritus, Agent Emeritus, Premier Retired Representative or Retired Representative;
- An independent contractor (other than an Agency Distribution Financial Professional);
- A service provider compensated through an employee leasing company, temporary employment agency or other third-party agency;
- An individual who would be treated as an employee solely by reason of such individual being treated as either part of an “affiliated service group” or a “leased employee” under the Internal Revenue Code and regulations; or
- Any other individual who performs services for the Company or an affiliate but is not treated as an Employee for Federal tax purposes at the time the individual renders services.

Please refer to the Plan Documents for a complete listing of the classes of Employees who are ineligible to participate in the Retiree Medical Program. See also “Who Is Not Eligible” beginning on page 15 of this SPD booklet.

ERISA
ERISA is the Employee Retirement Income Security Act of 1974, as amended, which is the Federal statute governing private pension and welfare plans.

Experimental or Investigational
A drug, a device, a procedure or treatment will be determined to be Experimental or Investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved;
- Approval required by the FDA has not been granted for marketing;
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental or Investigational, or for research purposes;
It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or

The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental or Investigational, or for research purposes.

Extended Family Member
To meet the eligibility requirements of an Extended Family Member under a program, your Extended Family Member must meet all of the following criteria:

- Be age 18 or older, but not have reached the first day of the month in which he/she attains Medicare eligibility. In situations where the Extended Family Member is not eligible for Medicare (for example, a non-U.S. citizen), eligibility ends at either the end of the month during which he/she attains age 65 (for all birth dates that do not fall on the first of a month) or on the date he/she attains age 65 (for all birth dates that fall on the first of a month);

- Meet the definition of a “Qualifying Relative” as defined in Internal Revenue Code Section 152 (without regard to the requirement that the child has gross income less than the exemption amount or whether the Extended Family Member has dependents or has filed a joint return with his/her Spouse) during the period of coverage (including, but not limited to, being Substantially Dependent upon you);

- Have lived with you for at least six months and remain a member of your household during the period of coverage;

- Not otherwise be eligible for any Prudential Medical Program or Retiree Medical Program coverage under The Prudential Welfare Benefits Plan (for example, as a Prudential Employee);

- Be related to you as follows: mother, father, grandmother, grandfather, stepmother, stepfather, mother-in-law, father-in-law, brother, sister, stepbrother, stepsister, niece, nephew, aunt, uncle, son, daughter, stepson, stepdaughter, son-in-law, daughter-in-law, brother-in-law or sister-in-law, or any person (other than your Spouse) who, for that Calendar Year, lives with you and is a member of your household;

- Not file a joint return for Federal income tax purposes; and

- Be a citizen or resident of the United States, Canada or Mexico.

To newly enroll your Extended Family Member, you must follow the Extended Family Member certification process on the Prudential Benefits Center website (at [www.prubenefitscenter.com](http://www.prubenefitscenter.com)).

If you wish to change an existing dependent’s relationship type, such as if you wish to enroll an existing Qualified Dependent (for example, a child) as an Extended Family Member or, if you do not have access to a computer or the Internet or if you need more information, you may call the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and follow the prompts for Health and Welfare benefits.

Federal Legend Drug
A drug that, by law, can be obtained only by prescription and bears the label, “Caution: Federal law prohibits dispensing without a prescription.”
Fiduciary
One who exercises discretion on behalf of an ERISA plan and its participants in the management or disposition of ERISA plan assets or ERISA plan administration, or one who renders investment advice for a fee with respect to ERISA plan assets.

Financially Interdependent
A requirement for Domestic Partner eligibility, Financially Interdependent means that you and your Domestic Partner share the cost of food and housing. You both do not have to contribute equally or jointly for each of these expenses as long as you are both responsible for such costs.

Full-Time Employee
An Employee who is regularly (not on a temporary basis) working for Prudential at least the number of hours in Prudential’s normal full-time work week for the class of Employees to which the Employee belongs, but not less than 30 hours per week for purposes of benefits eligibility.

Generic Alternative
A Generic Alternative contains different active ingredients than a Brand-Name Drug, but may provide a similar effect when treating a specific condition.

Generic Drug
A Generic Drug is a drug that is not protected by a patent. Generic Drugs include FDA-approved Generic Equivalent Drugs and Generic Alternatives. Generally, Generic Drugs cost less than Brand-Name Drug counterparts.

Generic Equivalent Drug
An FDA-approved Generic Equivalent Drug contains the same active ingredients as its Brand-Name counterpart; and is the same in strength, purity, quality, and dosage form. A Generic Equivalent Drug is taken the same way as its Brand-Name counterpart.

Health Fund
A recordkeeping account that is established for each CDHP 80 and CDHP 90 participant. The Health Fund helps satisfy the annual Deductible.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)
HIPAA is a Federal law designed to protect people who move from one job to another, who are self-employed or who have medical conditions.

Health Savings Account (HSA)
A tax-favored custodial account that is used to pay for qualified health care expenses available in conjunction with a high deductible health program.

Home Health Care
The program covers certain services provided in a person’s home, as long as a doctor certifies, in writing, that Hospital care would be needed to provide such services if Home Health Care were not available.

The services and supplies included under Home Health Care must be ordered by a doctor and must be Medically Necessary.

In addition to visits by a home health agency in a person’s home, the programs cover:

- Part-time or intermittent nursing care provided by or under the supervision of a Registered Nurse or a Licensed Practical Nurse if a Registered Nurse is not available;

- Home health aid services;

- Physical, occupational or speech therapy by a qualified therapist;
• Dietary counseling;

• Medical social services;

• Medical supplies, drugs and medicines prescribed by a physician;

• Lab services (provided by or for a Home Health Care agency); and

• Private duty nursing care provided outside of a Hospital or other facility by a Registered Nurse or Licensed Practical Nurse and required for treatment of an acute illness or injury. The programs do not cover Custodial Care (such as dressing, bathing and toileting) provided by a Registered Nurse, a Licensed Practical Nurse or otherwise.

In no event will the following services or supplies be covered under the program as Home Health Care:

• Custodial Care, which is non-skilled, personal care provided to help a person in the activities of daily living, such as bathing, dressing, eating, transferring (for example, from a bed to a chair) and toileting. It may also include care that most people do for themselves such as food preparation, diabetes monitoring and/or taking medications which can usually be self-administered;

• Services that do not require the technical skills of a medical, Mental Health or dental professional;

• Services furnished mainly for the personal comfort or convenience of the person, any person who cares for him/her, any person who is a part of his/her family, any health care provider or any health care facility;

• Services that are considered “Maintenance Care,” which serve to prevent an existing condition from getting worse rather than to actively treat the condition;

• Transportation services;

• Services and supplies not Medically Necessary; and

• Services and supplies that are not appropriately provided for the care of a diagnosed sickness or injury.

If a service provider furnishes a person both Home Health Care services and other services not covered under the programs (such as Custodial Care), the programs shall pay solely for the Home Health Care services and not for any non-covered services (such as Custodial Care). The Administrative Committee (or its delegate), in its sole discretion, shall determine the extent to which charges of any provider constitute Home Health Care services reimbursable by the programs or non-covered services (such as Custodial Care).

**Hospice Care**

Hospice Care is a program of care that is:

• Provided by a Hospital, skilled nursing facility, Hospice Care facility or Hospice Care agency;

• Approved by the Claims Administrator; and

• Focused on palliative rather than curative treatment for a person who is terminally ill.

**Hospital**

A Hospital is a place that:

• Mainly provides Inpatient facilities for the medical, surgical and psychiatric diagnosis, treatment and care of injured and sick persons;

• Is supervised by a staff of physicians;
• Provides 24-hour-a-day R.N. service;

• Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics or a nursing home; and

• Charges for its services.

**Imputed Income**

Imputed Income is the value of certain benefits you receive from Prudential that is considered income to you under current federal and state tax laws. This may include the value of any Prudential-paid life insurance coverage in excess of $50,000 and the value of Domestic Partner medical and/or dental coverage. The Imputed Income amount is determined as prescribed under the Internal Revenue Code and/or state tax laws. In some states, Imputed Income may include the value of health care coverage for a same-sex Spouse.

**Indemnity**

Indemnity is defined as a benefit paid by an insurer for a loss insured under a policy. Indemnity refers to a traditional fee-for-service medical program (for example, Retiree Medical Program E – Indemnity) which allows you to choose the doctor and Hospital you wish to use. The Retiree Medical Program option pays a percentage of the Reasonable and Customary (R&C) Fee for Covered Services after you meet an annual Deductible.

**Independent Review Organization (IRO)**

An Independent Review Organization (IRO) is an organization that conducts independent external medical reviews of adverse health care benefit determinations and final adverse benefit determinations. Under Federal law, IROs must be accredited by URAC, formerly known as the Utilization Review Accreditation Commission, or a similar nationally recognized accrediting organization. The IRO will review the claim in accordance with evidence-based medical guidelines to provide an impartial determination that is consistent with recognized medical standards.

**In-Network**

In-Network benefits are provided by a group of doctors, Mental Health clinicians, dentists, Hospitals and pharmacies that participate in a program’s Managed Care network. The Participating Providers agree to provide care and services at Negotiated Rates in exchange for participation in the network.

**Inpatient**

A person is an Inpatient when he/she is admitted to a Hospital or other care facility for one or more days as a registered, overnight bed patient. The word “Inpatient” also is used to describe care given to such a person (as in “Inpatient surgery”).

**Intensive Outpatient Programs**

Intensive Outpatient Programs treat mental illness and Substance Use Disorder conditions with therapy sessions that are usually at least two hours long. Intensive Outpatient Programs are typically six to eight weeks in duration with sessions between three and five days per week.

**Internal Revenue Code**

The Internal Revenue Code of 1986, as amended, is the Federal statute governing taxes and certain benefits plans and programs.

**International Employee**

An employee or retiree who is not or was not an Employee of a Participating Employer operating in the United States of America and is or was compensated for services rendered for an Affiliate in currency other than currency of the United States of America and paid from a payroll system other than that used by a Participating Employer to pay Employees in the United States of America.
Long Term Disability
In order to be eligible for benefits under the Retiree Medical Program described in this SPD booklet, a Long Term Disability participant is defined as having ten or more years of Vesting Service as of the date that benefits under the Long Term Disability Program commenced.

Maintenance Care
Services intended to prevent an existing condition from getting worse rather than to actively treat the condition.

Maintenance Care is not covered under the Retiree Medical Program.

Managed Care
Managed Care is an approach to health care cost containment with the goal of delivering cost-effective care without sacrificing quality or access to health care providers. A Managed Care network is a national or regional organization of Participating Providers offered to employers either as an alternative to, or total replacement for, traditional Indemnity insurance.

Maximum Lifetime Benefit
The maximum dollar amount a program will pay toward the cost of health care for a covered individual over his/her lifetime.

Medically Necessary
A Medically Necessary service, confinement or supply is one that is prescribed by a licensed physician for the diagnosis or treatment of a sickness or injury and is generally accepted and in use by the medical community for the condition being treated or diagnosed.

However, the fact that a physician prescribes a service, confinement or supply for a covered individual does not ensure that it will be considered an Eligible Expense under the Retiree Medical Program. The health care carrier will make the final decision as to what is Medically Necessary.

Please keep in mind that the health care carrier may use its own established protocols to determine what services or devices are Covered Charges or Covered Expenses including, but not limited to, the use of clinical policy bulletins, coverage positions and/or coverage criteria. You should contact your health care carrier directly for more details.

Medicare
Medicare is a nationwide, Federally administered health insurance program that covers the cost of hospitalization, medical care and some related services for people age 65 or over or to people who have received Social Security disability payments for two years. Medicare has two parts for medical coverage and one part for Prescription Drug coverage:

• Medicare Part A provides basic Hospital insurance for you and your Qualified Dependents if you are eligible for Medicare. Up to specified limits, Medicare Part A helps pay for:
  — Hospital and skilled nursing facility stays;
  — Home Health Care;
  — Hospice Care; and
  — Blood you receive during a covered Hospital or skilled nursing facility stay.

This coverage is provided to you at no cost if you enroll in Medicare Part A before you reach age 65.

• Medicare Part B is a voluntary program that provides supplemental medical insurance for you and your Qualified Dependents if you enroll in Medicare Part B as soon as you are eligible. Up to specified limits, Medicare Part B helps pay for:
  — Medical and other services, including doctors’ services (except for routine physical exams), Outpatient medical and surgical services and supplies, diagnostic tests, ambulatory surgery
center facility fees for approved procedures, durable medical equipment (for example, wheelchairs, Hospital beds, oxygen and walkers), Outpatient physical and occupational therapy (including speech-language therapy), second surgical opinions and Outpatient Mental Health care;

— Clinical laboratory services;

— Home Health Care;

— Outpatient Hospital services; and

— Blood you receive during a covered Hospital or skilled nursing facility stay.

You are required to make monthly contributions for Medicare Part B coverage.

• Medicare Part D offers optional Prescription Drug coverage to Medicare participants. Medicare Part D requires you to pay a monthly premium. Medicare Part D enrollment is voluntary and you may find that you will not need to enroll if you are satisfied with the benefits your Prescription Drug coverage provides through or in conjunction with your Prudential Retiree Medical Program option, although this is a question you must decide on your own after you compare the Prudential program to the Medicare Prescription Drug plans in your area. If you enroll, the Medicare Part D Prescription Drug coverage will be primary and the Prescription Drug coverage provided through or in conjunction with your Prudential Retiree Medical Program option will be secondary.

Mental Health
Mental Health refers to a state of emotional and psychological well-being. Mental Health treatment is rendered by clinicians such as psychiatrists, psychologists and social workers and focuses on disorders such as depression, anxiety and Substance Use Disorder. In the past, this SPD booklet had used the term “behavioral health” to refer to Mental Health and Substance Use Disorder (formerly referred to as Substance Abuse). (See “Substance Use Disorder” on page 235 for related information.)

National Preferred Formulary
Express Scripts’ list of Brand-Name Drugs and Generic Drugs that have an established track record of effectiveness in terms of treatment and cost.

Negotiated Fee/Rate
Negotiated Fee/Rate is the maximum amount a Participating Provider has agreed to charge the health care carrier to provide a service or supply to its members. Generally, the Negotiated Fee/Rate will not exceed the Reasonable and Customary (R&C) Fee for health care services.

Non-Benefit Claim
A Non-Benefit Claim means any claim other than a claim for benefits. Unless they are part of a claim for health care benefits, enrollment and eligibility claims are considered Non-Benefit Claims.

Non-Occupational Illness
A Non-Occupational Illness is an illness that does not arise out of (or in the course of) any work for pay or profit or result in any way from an illness that does. An illness will be deemed to be non-occupational regardless of cause if proof is furnished that the person is covered under any type of workers’ compensation law and is not covered for that illness under such law.

Non-Occupational Injury
A Non-Occupational Injury is an accidental bodily injury that does not arise out of (or in the course of) any work for pay or profit or result in any way from an injury which does.

Office Visit
A formal, face-to-face contact between a physician and a patient in a health center, office or Hospital Outpatient department.
Out-of-Network
Out-of-Network coverage under the HDHP, the CDHP 80 and the CDHP 90 works as an Indemnity plan or the traditional fee-for-service group health insurance plan, which allows you to choose the doctor and Hospital you want to use. You will generally have higher out-of-pocket expenses if you go Out-of-Network for your medical care than you will if you use a Participating Provider.

Outpatient
An Outpatient is a person who receives services from a Hospital or other care facility without being admitted as a registered, overnight bed patient. The word “Outpatient” also is used to describe care given to such a person (as in “Outpatient surgery”).

Partial Hospitalization Program
An intensive outpatient treatment program for serious mental disorders that typically ranges between three but less than 24 hours per day. Usually Partial Hospitalization Programs are delivered in a Hospital setting and support the transition from Inpatient to Outpatient care. Although timeframes vary, these programs may involve five days per week and may be full or half days as well as evenings and weekends.

Participating Affiliate or Participating Employer
The Company and its Affiliated Companies that elect to participate in the benefits plan or program.

Participating Provider
A Participating Provider has entered into a contractual agreement with the Claims Administrator to provide services to enrolled members.

Part-Time Employee
A Part-Time Employee is an Employee who is regularly (not on a temporary basis) working for Prudential less than the number of hours in Prudential’s normal full-time work week for the class of Employees to which the Employee belongs and who is regularly scheduled to work at least the number of hours per week that is required for eligibility for the applicable plan or program, if any. (Part-Time Employees do not include part-time field force marketing assistants.)

Plan Administrator
Generally, the Plan Administrator is the entity that has overall responsibility for administration of a benefits plan or program, including interpreting the Plan Documents, establishing procedures, recordkeeping and filing all necessary reports regarding the benefits plan or program and publishing and distributing communication materials. The Plan Administrator is the Administrative Committee.

Plan Document(s)
The Plan Documents are the written documents describing all the benefits and limitations pertaining to a particular Employee benefits plan or program.

Plan Sponsor
The Plan Sponsor is the employer establishing a benefits plan or program for its eligible participants and/or beneficiaries. The Prudential Insurance Company of America is the Plan Sponsor for all plans and programs described in this SPD booklet.

Plan Trustee
The Plan Trustee is the person or entity that holds title to and administers certain of the assets of certain benefits plans or programs for the benefit of participants and beneficiaries. The Plan Trustee for each of the ERISA benefits plans and programs is listed in this SPD booklet.

Plan Year
The Plan Year is the period used for all plan administration accounting and reporting. The Plan Year for each of the benefits plans or Programs is the Calendar Year, beginning each January 1 and ending the following December 31.
Post-Service Claim
A Post-Service Claim means any health claim that is not a Pre-Service, Concurrent Care or Urgent Care Claim.

Precertification
Precertification is the process of obtaining approval for benefits before care begins. Under the Prudential Retiree Medical Programs, you are required to obtain Precertification for certain procedures (for example, Out-of-Network Hospital stays) before the Program provides benefits.

Prescription Drug
A Prescription Drug is:

- A medicinal substance that, by law, can be dispensed only by prescription;
- A compound medication that includes a substance described above;
- Prescribed injectable insulin and insulin syringes; and
- Certain conditionally eligible drugs, but only if they are pre-authorized.

Pre-Service Claim
A Pre-Service Claim means any health claim that requires approval of the benefit before obtaining medical care.

Preventive Care/Services
Preventive Care/Services is a comprehensive type of care emphasizing priorities for prevention, early detection and early treatment of conditions.

Primary Care Physician (PCP)
In a Managed Care program, your PCP is the physician who is responsible for coordinating all your care, from providing direct care services to referring you to Specialists and Hospital care, when required.

Prudential
Prudential is The Prudential Insurance Company of America and its Participating Affiliates.

Prudential’s Group Health Plans
The Medical, Dental, Vision, Long Term Care, Global Medical and Global Dental Programs under The Prudential Welfare Benefits Plan as well as the Medical Access Plan, the Executive Medical Access Plan and the Employee Assistance Program constitute Prudential’s Group Health Plans.

The Prudential Retiree Welfare Benefits Plan
An Employee benefits plan established by the Company effective January 1, 2014, to provide various health and welfare benefits for participants who are former employees of the Company. Benefits provided under the Plan effective January 1, 2014, include the Retiree Medical Savings Account, and effective March 31, 2014, include Medical, Dental and Vision.

The Prudential Welfare Benefits Plan (or “Plan”)
An Employee benefits plan established by the Company to provide various health and welfare benefits for participants. Benefits provided under the Plan include Medical (through March 30, 2014), Dental (through March 30, 2014), Vision (through March 30, 2014), Disability, Life Insurance, Long Term Care and Group Legal.

The Prudential Retiree Welfare Benefits Plan was established by the Company effective January 1, 2014, to provide various retiree health and welfare benefits previously provided by The Prudential Welfare Benefits Plan. Specifically, Retiree Medical Program benefits are provided under The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All references to
The Prudential Welfare Benefits Plan in this SPD booklet should be read to refer to The Prudential Retiree Welfare Benefits Plan effective March 31, 2014. All other terms, conditions, limitations and exclusions of this SPD booklet are hereby incorporated and form the summary plan description for The Prudential Retiree Welfare Benefits Plan.

Qualified Adult
A Qualified Adult is a person who meets certain eligibility requirements for a program and is not your Spouse. A Qualified Adult is a Domestic Partner or Extended Family Member, as defined in this Glossary.

Qualified Change in Status
A Qualified Change in Status is a situation in which you may change your program elections at any time other than during the Annual Enrollment Period.

Please note that this list does not include all changes in status.

Qualified Changes in Status include (but are not limited to):

• Your marriage, divorce, legal separation or annulment;
• The birth, adoption or placement of a child for adoption;
• A Qualified Adult becoming eligible for coverage;
• Losing coverage from your HMO, Medicare Advantage Program or Medicare Cost Program due to your moving out of the network service area, if enrolled in an HMO, Medicare Advantage Program or Medicare Cost Program;
• Losing coverage from any Prudential Retiree Medical Program option due to your moving to Hawaii if you are not eligible for Medicare;
• Losing coverage due to your moving out of Hawaii, if enrolled in Retiree Medical Program E – Indemnity or the Kaiser – Hawaii HMO and not eligible for Medicare;
• Loss of HDHP, CDHP 80, CDHP 90 or HMO coverage due to becoming Medicare-eligible;
• A change of coverage under a Qualified Dependent’s employer plan;
• Exhaustion of other COBRA coverage by you, your Spouse or Qualified Dependents; or
• A change in the employment status of you, your Spouse or Qualified Dependents (including a change in work site or change in place of residence) which affects the benefits enrollment for you or your Qualified Dependents.

Qualified Changes in Status do not include events such as (but not limited to):

• Your Retiree Medical Program option Participating Provider dropping out of the network;
• Any errors you make during the enrollment process; or
• Your misunderstanding of the Program or provisions of the Retiree Medical Program option in which you are enrolled.

Any change you request due to a Qualified Change in Status must be consistent with the change in your status.

Qualified Dependents
Qualified Dependents are:

• Your Spouse or one Qualified Adult. A Qualified Adult is defined as your same-sex or opposite-sex Domestic Partner or an Extended Family Member; and
• Your Dependent Child(ren), as defined in this Glossary.
Qualified Medical Child Support Order (QMCSO)

A Qualified Medical Child Support Order (QMCSO) is a court order issued under state domestic law requiring a parent to provide health care benefits to one or more children. Coverage under the program will be extended to a child covered by a QMCSO if:

• The QMCSO is issued while you are eligible for coverage; and

• The child meets the definition of a Qualified Dependent.

If a court has issued a QMCSO requiring coverage for a child under your health care program, you must provide the Prudential Benefits Center with a copy of the QMCSO via U.S. mail, and request the addition of the Dependent Child by visiting the Prudential Benefits Center website at www.prubenefitscenter.com or, if you do not have access to a computer or the Internet or if you need more information, by calling the Prudential Benefits Center at 1-800-PRU-EASY (1-800-778-3279) and following the prompts for Health and Welfare benefits.

You or your family may obtain, without charge, a copy of The Prudential Welfare Benefits Plan’s QMCSO procedures from the Prudential Benefits Center.

Qualifying Child

A “Qualifying Child” is defined under Code Section 152(a)(1) without regard to whether your child has dependents. Subject to Code Section 152, your child who has attained age 26, a child living in your home for whom you are the legal guardian, and/or your grandchild will be considered your “Qualifying Child” if such child or grandchild is an individual who:

• Is your child or stepchild or a descendant of your child or stepchild; and

• Has the same principal place of abode as you do for more than one-half of the Calendar Year; and

• Is younger than you and:
  — In the case of a child living in your home for whom you are the legal guardian or a grandchild, has not attained age 19 as of the close of the Calendar Year; or
  — In the case of a child living in your home for whom you are the legal guardian or a grandchild, is a student who has not attained age 26 as of the close of the Calendar Year; or
  — In the case of a child living in your home for whom you are the legal guardian or a grandchild or child who has attained at least age 26, is permanently and totally disabled at any time during the Calendar Year; and

• Has not provided more than one-half of his/her own support for the Calendar Year; and

• Has not filed a joint return with his/her spouse for the Calendar Year.

If you and one or more other individuals could otherwise claim your child or grandchild as a “Qualifying Child” the following applies:

• If both you and the other individual are parents of a child, your child would be your “Qualifying Child” if you are the parent with whom your child resided the longest; or if your child resided with both parents for the same amount of time, if you are the parent with the highest adjusted gross income;

• If only one of the individuals is the parent of your child, your child would be the “Qualifying Child” of that parent;

• If the parents of the child or grandchild can claim the child as a “Qualifying Child” for purposes of Section 152, but do not do so, the child or grandchild may be claimed by you as your “Qualifying Child” only if you have adjusted gross income higher than any other person who could claim the child or grandchild; or
• If neither parent could claim the child or grandchild, the child will be your “Qualifying Child” only if you are the individual with the highest adjusted gross income.

Qualifying Event
A Qualifying Event is an event that allows you to continue certain health care coverage under COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended). This event can be the loss of a job, death, divorce or a Qualified Dependent reaching the age of ineligibility. Specific Qualifying Events are described in this SPD booklet.

Qualifying Relative
Under The Prudential Welfare Benefits Plan, a “Qualifying Relative” is defined under Code Section 152(a)(2) without regard to the requirement that the child have gross income less than the exemption amount or whether a child living in your home for whom you are the legal guardian, a child age 26 or older or the grandchild has dependents. Subject to Code Section 152, a child living in your home for whom you are the legal guardian, your child age 26 or over or your grandchild would be your “Qualifying Relative” if such child or grandchild is generally an individual:

• Who is related to you as follows: your child or a descendant of your child, son, daughter, stepson, stepdaughter, son-in-law, daughter-in-law, brother-in-law or sister-in-law, or any person (other than your Spouse) who, for that Calendar Year, has the same principal place of abode as you do and is a member of your household; and

• For whom you provide over one-half the individual’s support for the Calendar Year or otherwise satisfy the special exception related to multiple support agreements under Code Section 152(d)(3) as described under the definition of Dependent Child(ren) above; and

• Who is not your “Qualifying Child” or any other individual’s “Qualifying Child” for the Calendar Year.

Reasonable and Customary (R&C) Fees
Charges determined by the health care carrier to be appropriate for the services performed. Health care carriers consider various factors, including—but not limited to—the following in determining the Reasonable and Customary Fees:

• The usual charge made by the provider for the same service when there is no group insurance coverage; and

• A charge for a service that is not above the prevailing fee in the area for a comparable service or supply. The health care carrier determines both the range and the area for the purposes of this determination.

Please keep in mind that the health care carrier may use its own established protocols to determine what services or devices are Covered Charges or Covered Expenses including, but not limited to, the use of clinical policy bulletins, coverage positions and/or coverage criteria. You should contact your health care carrier directly for more details.

If you are Medicare-eligible, the assignment of Medicare benefits rules also apply. See “Assignment of Medicare Benefits” beginning on page 186 for more information.

Residential Treatment Center
A Residential Treatment Center is a facility that meets all of the following criteria:

• Is accredited by a national accreditation organization such as the Joint Commission on Accreditation of Healthcare Organizations, the Council on Accreditation or the Commission on Accreditation of Rehabilitation Facilities;

• Holds a current state license;

• Provides 24-hour nursing care; and
• Has an onsite psychiatrist to provide weekly assessments.

Retiree/Retiree
Terms used to indicate that you have become eligible for benefits under the Prudential Retiree Medical Program, the Retiree Dental Program, the Retiree Life Insurance Program and the Retiree Vision Program. You may be eligible for these benefits at the time your employment with Prudential ends if you meet the terms of The Prudential Welfare Benefits Plan, including if you:

• Have ten or more years of Vesting Service (as defined under the Retirement Plan, and including any additional periods of Vesting Service granted under The Prudential Welfare Benefits Plan for the purpose of eligibility); and

• Either:
  — Have attained the first day of the month coinciding with or next following your 55th birthday; or
  — Are considered a Retired Participant under the terms of The Prudential Traditional Retirement Plan (a component of the Retirement Plan).

Retiree Medical Savings Account (RMSA)
A method by which Prudential provides financial support for Retiree medical coverage beginning January 1, 2008. Employees retiring in 2008, 2009 and 2010 had a one-time irrevocable choice between the Credit Approach and the Retiree Medical Savings Account. The RMSA is the only method of financial support for eligible Employees who retire on or after January 1, 2011. The RMSA is a recordkeeping account that you can use to reimburse yourself for the Cost of certain medical, pharmacy, dental and vision premiums.

Retirement Plan
The “Retirement Plan” refers to The Prudential Merged Retirement Plan, which is a defined benefit pension plan. It was first adopted in 1941, and has been amended over the years. The Retirement Plan consists of The Prudential Traditional Retirement Plan Document Component One (referred to as the “traditional pension formula”), the Prudential Securities Incorporated Cash Balance Pension Plan Document Component Two (the “PSI Plan”), and the Prudential Cash Balance Pension Plan Document Component Three (referred to as the “cash balance formula”).

Specialist
A Specialist is a physician who concentrates on medical or dental activities in a particular specialty of medicine, based on education and qualifications.

Spouse
“Spouse” whether capitalized or lowercase, shall mean the person to whom a participant is legally married (whether the same or opposite sex) under the laws of any U.S. or foreign jurisdiction having the authority to sanction marriages.

Substance Use Disorder
Substance Use Disorder is the excessive use of a potentially addictive substance, such as alcohol or drugs, which is detrimental to an individual’s physical or Mental Health or the welfare of others. In the past, this SPD booklet had used the term “behavioral health” to refer to Mental Health and Substance Use Disorder (formerly referred to as Substance Abuse). (See “Mental Health” on page 229 for related information.)

Substantially Dependent
To be considered Substantially Dependent, your children and/or Extended Family Members must receive more than 50% of their maintenance and support from you or your Spouse, as defined by the Internal Revenue Code (Section 152).
Surviving Dependent
In order to be eligible for benefits under the Retiree Medical Program described in this Retiree Medical Program SPD booklet, a Surviving Dependent is defined as qualifying as a Spouse or Dependent Child who was covered under a Prudential-sponsored medical program at the time of the death of an eligible Prudential Retiree, an eligible Long Term Disability participant or an eligible active Employee with ten or more years of Vesting Service. Domestic Partners, Extended Family Members and civil union partners are not eligible for coverage as Surviving Dependents.

Urgent Care Claim
An Urgent Care Claim means any health claim for care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of your claim.

Urgent Condition (for the Aetna HMO and companion coverage under the Aetna Medicare Advantage Program only)
An Urgent Condition means a sudden illness, injury or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a Hospital; and
- Requires immediate Outpatient medical care that cannot be postponed until your physician becomes reasonably available.

Services provided for care of an Urgent Condition would not necessarily constitute an Urgent Care Claim.

U.S. Expatriate
An Employee who is a citizen of the United States or a non-U.S. citizen, hired by a U.S. Affiliate and paid from the U.S. payroll who is on assignment to perform services outside of the United States for a period that is expected to exceed three months, and who is designated by the SVP (as defined in The Prudential Welfare Benefits Plan) or his/her delegate as a U.S. Expatriate.

Usual and Prevailing Charge (for the Retiree Prescription Drug Program only)
The Usual and Prevailing Charge which may also be known as the “usual and customary” price is the price that a pharmacy provider would have charged for a prescription on the date of service if the member was a cash customer (i.e., the amount that is usually charged for pharmacy services). This price includes all applicable discounts such as senior citizen or promotional discounts.

Vesting Service
Vesting Service is determined in accordance with the Retirement Plan (and including any additional periods of Vesting Service granted under The Prudential Welfare Benefits Plan for the purpose of eligibility).

Generally, your Vesting Service includes time worked and certain approved or authorized time away from work, including vacations, holidays, sick days and certain time away on a paid or unpaid leave of absence. You receive credit for Vesting Service beginning with your first day of employment with the Company and its Affiliates and ending on the date your employment with the Company and its Affiliates ends. (See the Retirement Plan SPD booklet for more details.)