

Summary of Material Modifications of Claim Procedures

Effective Date: August 1, 2006

The following describes the current claims procedures followed by Prudential when processing Group Short Term Disability and Long Term Disability claims. It clarifies when a claim is considered to have been filed, and restates our current process for determining benefits and for the processing of appeals of adverse claim determinations. It is a Summary of Material Modifications (SMM), which is required to be disclosed to participants by federal law, and which explains the changes to the Summary Plan Description (SPD) of the Plan.

Claims Procedures

1. Filing of Disability Claims

Your disability claim will be considered filed when :

- If you have Short Term Disability (STD) coverage with Prudential, your claim for STD benefits will be considered filed the later of (1) when we receive your employee's statement, your employer's statement and your attending physician's statement, and (2) the start of your STD Elimination Period. (We interpret "statement" to mean, depending on the claim submission process in place with your employer, paper forms, electronic file feeds, web submissions, or information received via the telephone.)
- If you have Long Term Disability (LTD) coverage with Prudential, your claim for LTD benefits will be considered filed the later of (1) when we receive your employee's statement, your employer's statement and your attending physician's statement, and (2) the date that is 45 days before the end of your LTD Elimination Period. (We interpret "statement" to mean, depending on the claim submission process in place with your employer, paper forms, electronic file feeds, web submissions, or information received via the telephone.)
- If you have both STD and LTD coverages with Prudential and you have filed a claim for STD, there is no need to re-submit the statements noted above for the LTD portion of your claim. However, in this case your claim for LTD benefits will be considered filed the later of (1) when we receive the statements indicated above, and (2) the date that is 45 days before the end of your LTD Elimination period, provided you are receiving STD benefits on that date. If you are approved for STD benefits at a later date, your LTD claim will be considered filed on the date of the STD approval.

2. Determination of Benefits

Prudential shall notify you of the claim determination within 45 days of the date your claim is considered filed. This period may be extended by 30 days if such an extension is necessary due to matters beyond the control of the Plan. A written notice of the extension, the reason for the extension and the date by which the Plan expects to decide your claim, shall be furnished to you within the initial 45 day period. This period may be extended for an additional 30 days beyond the original 30-day extension if necessary due to matters beyond the control of the Plan. A written notice of the additional extension, the reason for the additional extension and the date by which the Plan expects to decide on your claim, shall be furnished to you within the first 30-day extension period if an additional extension of time is needed. However, if a period of time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination by Prudential will be tolled (i.e., suspended) from the date on

which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will be written in a manner calculated to be understood by you and shall include:

- (a) the specific reason(s) for the denial,
- (b) references to the specific plan provisions on which the benefit determination was based,
- (c) a description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary,
- (d) a description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals, and
- (e) if an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

3. Appeals of Adverse Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your denied claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by Prudential, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

Prudential shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

If the claim on appeal is denied in whole or in part, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by you and shall include:

- (a) the specific reason(s) for the adverse determination,
- (b) references to the specific plan provisions on which the determination was based,
- (c) a statement that you are entitled to receive upon request and free of charge reasonable access to, and copies of, all records, documents and other information relevant to your benefit claim upon request,
- (d) a description of Prudential's review procedures and applicable time limits,
- (e) a statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination, and
- (f) a statement describing any appeals procedures offered by the Plan, and your right to bring a civil suit under ERISA.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the earlier of the date on which you respond to the request for additional information and the deadline, if any, stated in the information request.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no affect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a written notification from Prudential of the denial. The notice will be written in a manner calculated to be understood by you and shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied upon appeal.