Medical

The Medical Plan offers several medical options to protect you and your eligible dependents against the high cost of treating major illness and injury.

The following information applies to all Citi medical options except HMOs. Your Benefits Resources™ lists the medical options available to you based on your home zip code. For information about a specific HMO, see the HMO information sheets on Your Benefits Resources™. If you are a new employee, you will receive these information sheets in your enrollment kit.

Depending on your location, you may choose from:

- ChoicePlan 500 Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan);
- High Deductible Health Plan Basic (Aetna Choice POS II Open Access);
- High Deductible Health Plan Premier (Aetna Choice POS II Open Access);
- Oxford PPO Health Plans (available in CT, NJ, and NY only) or
- Hawaii Health Plan (UnitedHealthcare, available in Hawaii only).

HMOs:

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States;
12. Presbyterian Health Plan (New Mexico); and
13. Sanford Health Plan (South Dakota).

Contents

Medical

Administrator of the ChoicePlans and Preferred Provider Organization (PPO)

The ChoicePlan is administered by Aetna and Empire BlueCross BlueShield throughout the United States. The ChoicePlan design is essentially the same no matter which vendor administers the Plan. The PPO is administered by Oxford Health Plans (a United Healthcare company).

Preventive care

Preventive care services are available in all non-HMO plans. Both exams and immunizations are covered by network providers at 100% with no deductible to meet.

Preventive care services include but are not limited to:

- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis and immunizations;
- Well-child-care services and routine pediatric care and immunizations for children, excluding travel immunizations; and
- Routine well-woman exams.

Contact the Plan for details.

Quick tip

Use the Health Care Spending Account (HCSA)/Limited Purpose Health Care Spending Account (LPSA) to save money on your out-of-pocket health care expenses. Since you forfeit any money remaining in the account that you do not use, estimate conservatively. See the *Spending Accounts* section for details.

Cancer screenings

In the ChoicePlan 500 and Oxford Health Plans PPO, cancer-screening tests are covered as follows:

- When performed by network providers: 100% with no deductible to meet;
- When performed by out-of-network providers: 100% up to $250, then covered at 70% of reasonable and customary charges, with no deductible to meet;

See the *Hawaii Health Plan* and *High Deductible Health Plan* sections for information on how cancer screenings are covered in those Plans.

Cancer screening tests are:

- Pap smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy; and
- PSA test.

Using an emergency room

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must notify your Plan within 48 hours. If you are not able to do this, have a family member contact your Plan.

The Citi Plans do not cover non-emergency services provided in an emergency room.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. Generally, urgent care centers have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, or the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Genetic Information Nondiscrimination Act of 2008

Effective January 1, 2010, under to the Genetic Information Nondiscrimination Act of 2008 (GINA), genetic information cannot be requested, required, or purchased for underwriting purposes or before enrollment. You and your dependents cannot be required to undergo genetic testing. Genetic information cannot be used to adjust premiums or contributions. The Plan may use the minimum necessary amount of genetic testing results to make determinations about claims payments.

Newborns' and Mothers' Health Protection Act notice

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours, or 96 hours, as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours.

Women's Health and Cancer Rights Act notice

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMOs provide this coverage, subject to applicable deductibles and coinsurance.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you also will be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema.

Precertification/ notification

Precertification/notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting, and that your health care costs and Citi's costs are kept under control. The following sections describe the precertification/notification features of each Plan. Be sure to read the sections that apply to the Plan available to you.

Precertification requirements for Aetna plans

If you are enrolled in Aetna ChoicePlan 500 or the High Deductible Health Plan – Basic or High Deductible Health Plan – Premier you must call Aetna to precertify any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services must be precertified at least 14 days in advance. Outpatient procedures must be precertified at least five days in advance. Aetna must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify Aetna of emergency hospitalization or other emergency services occurring outside the United States.

Inpatient confinements

For inpatient confinement, you must call Aetna for precertification at least 14 days prior to the scheduled admission date. An admission date may not have been set when the confinement was planned. You must call Aetna again as soon as the admission date is set.

You must obtain precertification for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call within 48 hours after the admission.

Outpatient surgery/diagnostic testing

If you are enrolled in the Aetna ChoicePlan, when you receive care from an out-of-network provider, you must obtain precertification for the following services:

- Bunionectomy — surgical removal of a bunion;
- Carpal tunnel surgery — surgical treatment of carpal tunnel syndrome;
- Colonoscopy — colon exam;
- Coronary angiography — examination of vessels using radiographic imaging technology;
- CT scan of the spine — cross-sectional scan of the spine;
- Diagnostic tests for organ or tissue transplants;
- Dilation and curettage (D&C) — surgical scraping of the uterus;
- Hammertoe repair — interphalangeal fusion, filleting, and/or phalangectomy;
- Hemorrhoidectomy — surgical removal of hemorrhoids;
- Knee arthroscopy — interior examination of the knee joint;
- Laparoscopy (abdominal) — interior examination of the abdomen;
- MRI of the knee — examination of the knee using imaging technology;
- MRI of the spine — examination of the spine using imaging technology;
- Nasal endoscopy — visual examination of the nose by means of an endoscope;
- Rhinoplasty — plastic surgery of the nose;
- Septoplasty — surgery of the nasal wall;
- Tympanostomy tube — insertion of a tube in the middle ear; and
- Upper gastrointestinal endoscopy — interior examination of the stomach and intestines.

For outpatient services that require precertification, you must call Aetna for precertification at least five working days before the service is given.

Mental health/chemical dependency

You must call Aetna for precertification before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify Aetna before the scheduled date of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

See organ/tissue transplants in “Covered services and supplies” on page 78 for information about precertification requirements. Aetna will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

- Aetna should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- You must notify the Plan to certify inpatient confinement for delivery of a child. This is to certify a length of stay that exceeds:
  - 48 hours following a normal vaginal delivery; or,
  - 96 hours following a cesarean section.
- For inpatient care (for either the mother or child) that continues beyond the 48/96-hour limits stated above, Aetna must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician does not agree with Aetna’s determination, you may appeal the decision. For

information about the claims appeal process, see “Claims and appeals for Aetna medical plans” on page 98.

Precertification for ChoicePlan 500 administered by Empire BlueCross BlueShield

You are required to obtain precertification for both network and out-of-network services. Your network doctor does *not* obtain precertification on your behalf.

Your Plan reviews and determines whether hospitalization and non-emergency surgery are medically necessary.

In case of an unscheduled or emergency admission, you or your doctor must call your Plan within two business days after the admission.

When traveling outside the United States, you are not required to obtain precertification for emergency hospitalization or other emergency services.

No benefits are payable unless Empire BlueCross BlueShield determines that the services and supplies are covered under the Plan.

You are required to obtain precertification for the following services:

- Inpatient facility admissions, including emergency admissions and inpatient physical rehabilitation;
- Home health care services, including private-duty nursing
- Hospice care;
- Admission to a skilled nursing facility;
- Air ambulance;
- Outpatient surgery
  - at least 14 working days prior to the service being provided.
- Mental health/chemical dependency
- Organ/tissue transplants
  - Call Empire BlueCross BlueShield before the scheduled date of any of the following:
    - The evaluation;
    - The donor search;
    - The organ procurement/tissue harvest; and
    - The transplant.

  See organ/tissue transplants in “Covered services and supplies” on page 78 for information about precertification requirements. Empire BlueCross BlueShield will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.
- Pregnancy
  - Pregnancy is subject to the following notification time periods:
    - For inpatient confinement for delivery of child, you should certify a length of stay in excess of:
      - 48 hours following a normal vaginal delivery or
      - 96 hours following a cesarean section.
    - For inpatient care (for either the mother or child) that continues beyond the 48/96 hour limits stated above, Empire BlueCross BlueShield should be notified before the end of these time periods.
    - Call Empire’s Maternity Care program to ensure you receive maximum benefits and pregnancy-related materials.

  If you or your physician does not agree with Empire BlueCross BlueShield’s determination, you may appeal the decision. For more information about the claims appeal process, see “Claims and appeals for Empire BlueCross BlueShield medical plans” on page 100 or call 1-866-290-9098.

Precertification for Oxford Health Plans PPO

The following services require precertification if you are enrolled with Oxford Health Plans:

- Hospital and other facility admissions, including emergency admissions;
- Home health care services, including private-duty nursing;
- Reconstructive procedures;
- Hospice care;

- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Dental services (accident only);
- Durable medical equipment with a retail cost of more than $1,000 whether for purchase or rental; and
- Transplant services.

Network services: Your PCP or other network provider will handle the precertification process for you when you receive any network services.

Out of network services: When you receive care from an out of network provider, you must receive precertification before receiving any of the listed services.

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must precertify the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call Oxford Health Plans again as soon as the admission date is set. You must receive precertifications for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call within 48 hours after the admission. If you are not able to call, have a family member contact UnitedHealthcare.

Outpatient surgery/diagnostic testing/other services

When you receive care from an out of network provider, you must receive precertification before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $1,000 or more.

For outpatient services that require precertification, you must receive precertification at least five working days before the service is given.

Mental health/chemical dependency

You must receive precertification before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must receive precertification at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following precertification time periods:

- Precertification should be requested through Oxford Health Plans during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program.
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, Oxford Health Plans must receive a precertification request before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires precertification as a scheduled confinement.

If you or your physician does not agree with Oxford Health Plans determination, you may appeal the decision. For information about the claims appeal process, see “Claims and appeals for Oxford Health Plans medical plans” on page 102.

Precertification requirements for Hawaii Health Plan

When you receive care from any provider, whether network or out of network, you must notify UnitedHealthcare before receiving any of the listed services. If you don't notify UnitedHealthcare, you will be subject to a penalty of $400 per admission (to a maximum penalty, in the aggregate, of $1,000 per calendar year).

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must notify UnitedHealthcare of the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call UnitedHealthcare again as soon as the admission date is set. You must notify UnitedHealthcare for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private-duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call *within* 48 hours after the admission.

Outpatient surgery/diagnostic testing/other services

When you receive care from an out of network provider, you must notify UnitedHealthcare before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $1,000 or more.

For outpatient services that require notification, you must notify UnitedHealthcare at least five working days before the service is given.

Mental health/chemical dependency

You must notify UnitedHealthcare before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify UnitedHealthcare at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following notification time periods:

- UnitedHealthcare should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program.
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, UnitedHealthcare must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician does not agree with UnitedHealthcare's determination, you may appeal the decision. For information about the claims appeal process, "Claims and appeals for UnitedHealthcare medical plans" on page 96.

ChoicePlan 500

ChoicePlan 500 at a Glance

Type of service	*Network*	*Out of network*
Annual deductible		
• Individual	• $500	• $1,500
• Maximum per family	• $1,000	• $3,000
Annual out-of-pocket maximum (includes deductible)		
• Individual	• $3,000	• $6,000
• Maximum per family	• $6,000	• $12,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP visits	• 90% after deductible	• 70% of R&C after deductible
• Specialist visits	• 90% after deductible (Aetna: 95% after deductible Aexcel specialist)	• 70% of R&C after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of R&C after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well child visits and routine immunizations • Cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening) • The $250 annual credit per person applies to out of network wellness services	• 100% no deductible	• 100% no deductible, up to $250 maximum, then covered at 70% of R&C • Immunizations covered at 70% of R&C, no deductible
Routine care (subject to frequency limits)		
• Routine vision exams	• 100% no deductible, limited to one exam every 24 months	• 100% no deductible, up to $250 maximum, then covered at 70% of R&C, limited to one exam every 24 months
• Routine hearing exams	• 90% after deductible, limited to one exam every 24 months	• Not covered
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, and surgical care	• 90% after deductible; precertification is required for hospitalization and certain outpatient procedures	• 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of R&C after deductible
• Hospital delivery	• 90% after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	• 70% of R&C after deductible • Pre-notification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room • (includes emergency room facility and professional services provided in the emergency room)	• $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization)	• $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization)
• Urgent care facility	• 90% after deductible	• 90% after deductible
Non-routine outpatient lab and X-ray services	• 90% after deductible	• 70% of R&C after deductible

Medical

Type of service	*Network*	*Out of network*
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy All therapy visits are reviewed for medical necessity. PT/ST/OT therapy visits are combined with a 60-visit maximum. Additional visits over the maximum are reviewed on a case-by-case basis for medical necessity.	• 90% after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy combined. This limit applies to network and out of network services combined • 70% after deductible for visits approved for medical necessity over plan limit.	• 70% of R&C after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy combined. This limit applies to network and out of network services combined • 50% of R&C after deductible for visits approved for medical necessity over plan limit.
• Chiropractic therapy (medically necessary)	• 90% after deductible, up to 20 visits per year for network and out of network services combined	• 70% of R&C after deductible, up to 20 visits per year for network and out of network services combined
Durable medical equipment (includes orthotics/prosthetics and appliances)	• 90% after deductible	• 70% of R&C after deductible
Private-duty nursing and home health care	• 90% after deductible, limited to 200 visits annually for network and out of network services combined; precertification required	• 70% of R&C after deductible, limited to 200 visits annually for network and out of network services combined; precertification required
Hospice	• 90% after deductible; precertification required	• 70% of R&C after deductible; precertification required
Skilled nursing facility	• 90% after deductible (limited to 120 days annually for network and out of network services combined); precertification required	• 70% of R&C after deductible (limited to 120 days annually for network and out of network services combined); precertification required
Infertility treatment	• Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. • Network: 90% after deductible up to the family lifetime maximum network • Out of network: 70% of R&C after deductible up to the family lifetime maximum	
	• Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	
	• Contact the Claims Administrator for specific coverage.	
Prescription drugs (refer to *Prescription Drugs* section)		
Mental health and chemical dependency (refer to "Mental health/chemical dependency in and out of network" on page 53)		

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 78 and "Exclusions and limitations" on page 89.

Under ChoicePlan 500, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a preferred provider or a non-preferred provider. Using preferred providers (network) saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the reasonable and customary (R&C) amounts. Second, the level of reimbursement for many services is higher when using preferred providers. *Citi plans only cover services that are deemed medically necessary.*

ChoicePlan 500 network features

Deductible

If you elect to use physicians or other providers in the network, you will need to satisfy an annual deductible of $500 individual/$1,000 family before any benefit will be paid. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

The individual deductibles apply to all covered expenses except preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductibles. The family deductibles can be met as follows:

- Two in a family: Each member must meet the $500 individual deductible or
- Three or more in a family: Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts.

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have satisfied the deductible. For example, if the Plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered in the network is $3,000 (individual)/$6,000 (family). This amount represents the most you will have to pay out of your own pocket in a calendar year for network services. This amount does not include network copayments, penalties, or services not covered under ChoicePlan 500. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. However, network copayments still apply even after the out-of-pocket maximums are met.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amounts ($3,000) to the family out-of-pocket maximums $6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Charges above reasonable and customary amounts;
- Emergency room copayment;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under ChoicePlan 500.

Expenses incurred when using out of network services count toward your network out-of-pocket maximum. Network and out of network, out-of-pocket maximums cross-accumulate.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from the primary care physicians in the directory of network providers. A directory of the network providers who participate in ChoicePlan 500 is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call 1-800-545-5862
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; to access a network provider through the Blue Cross Blue Shield Association BlueCard ® PPO Program, select "Find a Doctor," and then choose "Across the Country (National Provider Search)." Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select PPO/EPO on the right side of the screen and click on "Next." You will have a variety of search options to help you find a provider that meets your needs. You also may call 1-866-290-9098.
- Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Aetna Aexcel specialists

Aexcel is a designation within Aetna's network that includes specialists who have demonstrated effectiveness in the delivery of care based on a balance of measures of clinical performance and cost-efficiency. Currently, there are Aexcel-designated physicians in 12 medical specialty categories: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics and gynecology, orthopedics, otolaryngology, neurology, neurosurgery, plastic surgery, urology, and vascular surgery.

Aexcel-designated specialists are currently available to members in AZ, CO, CT, DC, DE, FL, GA, IL, IN, KY, MD, ME, MI, MO, NJ, NY, OH, OK, PA, TX, VA and WA.

When you visit an Aexcel specialist you do not need a referral. The Plan will pay 95% of covered expenses for Aexcel specialists. To find an Aexcel specialist visit, **www.aetna.com/docfind**; select the Aetna Standard Plans, Aetna Select, and look for the providers listed with the blue star. This blue star identifies the Aexcel specialists.

Allergist

When you see a network allergist, once you meet your deductible, you will be expected to pay 10% of the first office visit. If you receive an allergy injection only (without a physician office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, no deductible for the ChoicePlans.

Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claim Administrator;
- Routine diagnostic tests. For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the ChoicePlans will cover both cancer-screening tests, well-adult and well-child immunizations performed by network providers at 100%, no deductible. Cancer screenings are:

- Pap smear performed by a network provider annually;
- Mammogram at a frequency based on age:
  - Ages 35–39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Routine care

ChoicePlan 500 offers additional coverage for routine care services to help in the early detection of health problems.

- Routine eye exam: covered at 100%, no deductible, one exam every 24 months, performed by a network ophthalmologist or optometrist and
- Routine hearing exam: covered at 90%, after the deductible has been met, one exam every 24 months, performed by a network otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) received through a preferred provider is covered at 90% for covered services after the deductible has been satisfied. Services provided by a network physician in an out-of-network hospital are covered at the network benefit level. Please note that any charges submitted by an out-of-network hospital would be treated as out-of-network claims. Notification of an inpatient admission is required. Notification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $50 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Urgent care

Urgent care centers are listed in the provider directory that can be accessed on the Claim Administrators' websites. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 90% for covered services after the deductible has been satisfied.

Charges not covered

A network provider contracts with the ChoicePlan 500 Claims Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under ChoicePlan 500 or not approved by ChoicePlan 500. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under ChoicePlan 500 and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see the "Claims and appeals for UnitedHealthcare medical plans" on page 96.

Paying your bill at your network doctor's office

After you meet your annual deductible, the Plan will pay 90% for most covered services, while you will pay 10% of the Plan's negotiated rate. In most cases, your doctor will bill you for the 10%. Generally, you will not pay your network doctor on the day of your visit because you will have to wait for your portion of the charge to be calculated.

Choosing network providers

ChoicePlan 500 is administered by Aetna and Empire BlueCross BlueShield. When you enroll in ChoicePlan 500, you may request a provider directory that lists doctors and other providers who belong to the network by calling the Claims Administrator or by visiting the Claims Administrators' websites.

- Aetna: **www.aetna.com** select the Aetna Open Access, Choice POSII Open Access Plan or call 1-800-545-5862.
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; to access a network provider through the Blue Cross Blue Shield Association BlueCard ® PPO Program, select "Find a Doctor," and then choose "Across the Country (National Provider Search)." Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select PPO/EPO on the right side of the screen and click on "Next." You will have a variety of search options to help you find a provider that meets your needs. You also may call 1-866-290-9098.

Note: Before visiting a network provider, contact him or her to confirm participation in your Plan's network. Provider lists are kept as current as possible, but changes can occur between the time you review the list of providers and the start of your coverage.

Out-of-network features

You can use an out of network provider for medical services and still receive reimbursement under ChoicePlan 500. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out of network services or appeal a denied claim, see the "Claims and appeals for UnitedHealthcare medical plans" on page 96, "Claims and appeals for Aetna medical plans" on page 98, and "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 100.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible of $1,500 individual/$3,000 family maximum before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- Two in a family: Each member must meet the $500 network/$1,500 out of network individual deductible; or
- Three or more in a family: Expenses can be combined to meet the $1,000 network/$3,000 out of network family deductible, but no one person can apply more than the individual deductible ($500/$1,500) toward the family deductible amount.

Once you have met the deductible, ChoicePlan 500 normally pays 70% of reasonable and customary (R&C) charges for covered expenses that are received out of network.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered outside of the network is $6,000 (individual)/$12,000 (family). This amount includes the $1,500 individual/$3,000 family deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed R&C expenses, penalties, or services not covered under ChoicePlan 500. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of R&C for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount of $6,000 to the family out-of-pocket maximum of $12,000.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed reasonable and customary (R&C) amounts;
- Emergency room copayment;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under the Plan.

In addition, expenses incurred when using network services count toward your out of network, out-of-pocket maximum.

Preventive care

Each participant has a $250 annual credit toward all wellness services out of network. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of R&C. Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claim Administrator;
- Routine diagnostic tests: For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the ChoicePlans will cover both cancer-screening tests, well-adult and well-child immunizations performed by non-network providers. Well adult and child immunizations are covered 70% of R&C, with no deductible. Cancer screenings are covered at 100% with no deductible up to a maximum benefit of $250; thereafter such screenings are covered at 70% of R&C. Cancer screenings are the same as provided under in network coverage.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of R&C, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification of an inpatient admission is required. Notification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $50 per visit, same as in-network.

Urgent care

Services provided by an urgent care center are covered at 90% for covered services after the deductible has been satisfied. For Empire BlueCross BlueShield participants, services provided by a non-network urgent care center will be covered at 70% of R&C after the deductible has been satisfied.

Mental health/chemical dependency in and out of network

ChoicePlan 500 provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call your Claims Administrator before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; precertification required	After the deductible, eligible expenses covered at 70% of R&C; precertification required

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under ChoicePlan 500.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

ChoicePlan 500 pays benefits at the network level (90% of negotiated rate contracted with the Claims Administrator) if you call the Plan, use a network provider, and the treatment is medically necessary, and in the appropriate level-of-care setting. If you do not use a network provider, you will be reimbursed at 70% of R&C after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by ChoicePlan 500 in advance of the admission.

Outpatient services

If you use a network provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use a network provider, you will be reimbursed at 70% of R&C for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral; however you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. ChoicePlan 500's behavioral health providers are available 24/7 hours a day, seven days a week to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for a definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 78. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent Review and Discharge Planning

The following items apply if ChoicePlan 500 requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent Review.** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge Planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Oxford Health Plans Preferred Provider Organization (PPO) (CT, NJ, and NY only)

The Oxford Health Plans Preferred Provider Organization (PPO) is administered by Oxford Health Plans and is available in the Connecticut, New Jersey, and New York tri-state area. The Plan is self-insured, that is, it is not subject to state laws.

Under the Oxford PPO Plan, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a preferred provider or a non-preferred provider. Using preferred (network) providers saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the reasonable and customary (R&C) amounts. Second, the level of reimbursement for many services is higher when using preferred providers. For a list of providers, visit the Oxford Health Plans website at **www.oxhp.com** or call Oxford member services at 1-800-760-4566.

The Oxford PPO at a Glance

Type of service	Network	Out of network
Annual deductible		
• Individual	• $500	• $1,500
• Maximum per family	• $1,000	• $3,000
Annual out-of-pocket maximum (includes deductible)		
• Individual	• $3,000	• $6,000
• Maximum per family	• $6,000	• $12,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP visits	• 90% after deductible	• 70% of R&C after deductible
• Specialist visits	• 90% after deductible	• 70% of R&C after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of R&C after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening) • The $250 annual credit per person applies to out of network wellness services	• 100%, no deductible	• 100% no deductible, up to $250 maximum, then covered at 70% of R&C • Immunizations covered at 70% of R&C, no deductible
Routine care (subject to frequency limits)		
• Routine vision exams	• 100% no deductible, limited to one exam every 24 months	• 100% no deductible, up to $250 maximum
• Routine hearing exams	• 90% after deductible, limited to one exam every 24 months	• Not covered
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, and surgical care	• 90% after deductible; precertification is required for hospitalization and certain outpatient procedures	• 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of R&C after deductible
• Hospital delivery	• 90% after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	• 70% of R&C after deductible • Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	• $100 copayment (waived if admitted within 24 hours, precertification required)	• $100 copayment (waived if admitted within 24 hours, precertification required)
• Urgent care facility	• 90% after deductible	• 90% after deductible
Non-routine outpatient lab and X-ray services	• 90% after deductible	• 70% of R&C after deductible

Medical

Type of service	Network	Out of network
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy	• 90% after deductible • 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out of network services combined. • 70% after deductible for visits approved for medical necessity over Plan limit.	• 70% of R&C after deductible, • 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out of network services combined. • 50% of R&C after deductible for visits approved for medical necessity over Plan limit.
• Chiropractic therapy	• 90% after deductible, up to 20 visits per year for network and out of network services combined	• 70% of R&C after deductible, up to 20 visits per year for network and out of network services combined
Durable medical equipment (includes orthotics/prosthetics and appliances)	• 90% after deductible	• 70% of R&C after deductible
Private-duty nursing and home health care	• 90% after deductible, limited to 200 visits annually for network and out of network services combined; precertification required	• 70% of R&C after deductible, limited to 200 visits annually for network and out of network services combined; precertification required
Hospice	• 90% after deductible; precertification required	• 70% of R&C after deductible; precertification required
Skilled nursing facility	• 90% after deductible (limited to 120 days annually for network and out of network services combined); precertification required	• 70% of R&C after deductible (limited to 120 days annually for network and out of network services combined); precertification required
Prescription Drugs		
Retail	• $10 copay (tier 1), $20 copay (tier 2), $40 copay (tier 3) per prescription up to 30-day supply	• 50% covered
Mail Order	• $20 copay (tier 1), $40 copay (tier 2), $80 copay (tier 3) per prescription up to 90-day supply	• Not available
Infertility treatment	• CT: Deductible and coinsurance apply to covered services up to a $10,000 lifetime maximum for network and out of network services combined; 1 cycle of infertility treatment. • NJ: Deductible and coinsurance apply to covered services up to 4 egg retrievals per lifetime for network and out of network services combined. Precertification required. • NY: Covered at 100% for services up to a $10,000 lifetime maximum for network and out of network services combined.	
	• Contact Oxford for specific coverage details.	
Mental health and chemical dependency (refer to “Mental health/chemical dependency: in and out of network” on page 59)		

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see “Covered services and supplies” on page 78 and “Exclusions and limitations” on page 89.

How the Plan Works

Network coverage

To receive the highest level of benefits from the Oxford Health Plans, referred to as the network level of benefits, you must receive care from a preferred provider.

Deductible

If you use physicians or other providers in the network, you will need to satisfy an annual deductible ($500 individual/$1,000 family) before any benefits will be paid. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

The individual deductibles apply to all covered expenses except preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductibles. The family deductibles can be met as follows:

- **Two in a family:** Each member must meet the $500 individual deductible or
- **Three or more in a family:** Expenses can be combined to meet the $1,000 family deductible, but no one person can apply more than the individual deductible ($500) toward the family deductible amounts.

Coinsurance

Coinsurance refers to the portion of a covered expense that you pay after you have satisfied the deductible. For example, if the Plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

Out-of-pocket maximum

The out-of-pocket maximums for services rendered in the network are $3,000 individual/$5,000 family. This amount represents the most you will have to pay out of your own pocket in a calendar year for services received in the network. This amount does not include network copayments, penalties, or services not covered under the Oxford Health Plans. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. However, network copayments still apply even after the out-of-pocket maximums are met.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($3,000) to the family out-of-pocket maximum ($6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Pharmacy expenses and
- Charges for services not covered under Oxford Health Plans.

Expenses incurred when using out of network services count toward your network out-of-pocket maximum.

Network and out of network out-of-pocket maximums cross-accumulate.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from primary care physicians in the directory of network providers. A directory of the network providers who participate in Oxford Health Plans is available from the Claims Administrator. You may call or visit the Claims Administrator's website at **www.oxhp.com** or call 1-800-760-4566

Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Specialists

If you need the services of a specialist, you may seek care from a specialist directly without a referral. Once you meet your deductible, the Plan will pay 90% of covered network expenses.

Allergist

When you see a network allergist, once you meet your deductible, you will be expected to pay 10% of the first office visit. If you receive an allergy injection only (without a physician office visit charge), benefits will be covered at 100%. If services are for other than an allergy injection and you are charged for an office visit, coinsurance will apply.

Preventive care

Preventive care services are covered at 100%, no deductible.

Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claim Administrator;
- Routine diagnostic tests. For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the Oxford Health Plans will cover both cancer-screening tests and well-adult and well-child immunizations performed by network providers at 100%, no deductible. Cancer screenings are:

- Pap smear performed by a network provider annually;
- Mammogram at a frequency based on age:
  - Ages 35–39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Routine care

The Oxford Health Plans offer additional coverage for routine care services to help in the early detection of health problems.

- **Routine eye exam:** Covered at 100%, no deductible, one exam every 24 months, performed by a network ophthalmologist or optometrist and
- **Routine hearing exam:** Covered at 90% after deductible, one exam every 24 months, performed by a network otolaryngologist or otologist.

Infertility

The Oxford Health Plans cover expenses associated with infertility treatment. Since infertility coverage varies by state, please contact the Plan for details.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Charges not covered

A network provider contracts with the Oxford Health Plans Claims Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under Oxford Health Plans or not approved by Oxford Health Plans. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under Oxford Health Plans and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 102.

Out of network coverage

You can use an out of network provider for medical services and still receive reimbursement under the Oxford Health Plans. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out of network services or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 102.

Deductible and coinsurance

If you use physicians or other providers outside the network, you will need to satisfy an annual deductible ($1,500 individual/$3,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductibles apply to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductibles represent the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent’s individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the $1,500 individual deductible or
- **Three or more in a family:** Expenses can be combined to meet the $3,000 family deductible, but no one person can apply more than the individual deductible ($1,500) toward the family deductible amount.

Once you have met the deductible, Oxford Health Plan normally pays 70% of reasonable and customary (R&C)

charges for covered expenses that are received out of network.

Out-of-pocket maximum

The out-of-pocket maximum for services rendered outside of the network is $6,000 individual/ $12,000 family. This amount includes the ($1,500 individual and $3,000 family) deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed R&C expenses, penalties, or services not covered under the Oxford Health Plans. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of R&C for the remainder of the calendar year.

Eligible expenses within a family can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($6,000) to the family out-of-pocket maximum ($12,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed R&C;
- Pharmacy expenses; and
- Charges for services not covered under the Plan.

In addition, expenses incurred when using network services count toward your out of network, out-of-pocket maximum.

Preventive care

Each participant has a $250 annual credit toward all wellness services out of network. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of R&C . Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines. For frequency guidelines, contact your Claim Administrator;
- Routine diagnostic tests: For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the Oxford Health Plans will cover both cancer-screening tests, well-adult and well-child immunizations performed by non-network providers. Well adult and child immunizations are covered 70% of R&C, with no deductible. Cancer screenings are covered at 100% with no deductible up to a maximum benefit of $250; thereafter such screenings are covered at 70% of R&C. Cancer screenings are the same as provided under in-network coverage.

Infertility

The Oxford Health Plans cover expenses associated with infertility treatment. Since infertility coverage varies by state, please contact the Plan for details.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of R&C, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification of an inpatient admission is required. Notification is recommended for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $50 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Urgent care

Services provided by an urgent care center are covered at 90% for covered services after the deductible has been satisfied.

Mental health/chemical dependency: in and out of network

Oxford Health Plans provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the customer service telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call your Plan before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required
If you call the Plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 70% of R&C; precertification required	After the deductible, eligible expenses covered at 70% of R&C; precertification required

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the Plan medical necessity requirements, coverage limitations, and deductibles.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient care;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

Oxford Health Plans pays benefits at the network level (90% of negotiated rate contracted with the Claims Administrator) if you call the Plan, use a network provider, and the treatment is medically necessary and in the appropriate level-of-care setting. If you do not use a network provider, you will be reimbursed at 70% of R&C after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless precertified in advance of the admission.

Outpatient services

You are encouraged to call Oxford Health Plans for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of R&C for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral; however you are required to call Oxford Health Plans within 48 hours after an emergency admission. Oxford HealthPlans behavioral health providers are available 24/7 hours a day, seven days a week to accept calls.

Medically necessary

Oxford HealthPlans will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Behavioral Health department will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Behavioral Health department determines that the covered services and supplies are medically necessary. Please refer to the “Glossary” for a definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 78. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent Review and Discharge Planning

The following items apply if the Oxford Health Plans requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent Review:** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge Planning:** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be used by the member upon discharge from an inpatient stay.

Fully insured health maintenance organizations (HMOs)

Citi has entered into fully insured arrangements with numerous health maintenance organizations (HMOs) to provide health benefits to eligible employees. Although HMOs generally deliver benefits in the same way, the coverage that each HMO provides differs from the others.

This section provides a description of the medical benefit information available to HMO participants and should be read together with the *Eligibility and Participation* section, the *Administrative information* section, the HMO information sheets, and the HMO Certificate of Insurance listed under "2010 insured HMOs" on page 64. There is a separate HMO information sheet and HMO Certificate of Insurance for each fully insured HMO.

- *Eligibility and participation* and *Administrative information* provide you with information about eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.
- HMO information sheets provide a brief summary of the benefits available through each HMO and are included in this document. The information sheet for each HMO contains a link to a provider directory for each HMO, so that you can identify the health care providers who participate in that HMO's network.
- HMO Certificates of Insurance provide detailed information about the benefits and coverage available through each HMO. The HMO will send a Certificate of Insurance and a provider directory to you at your home upon enrollment in the HMO. If you do not receive your Certificate of Insurance, call your HMO at the telephone number on the HMO information sheet or on your ID card. The Certificate of Insurance for each HMO is included in this document. For example, the Certificate of Insurance will generally provide you with information concerning:
  - The nature of services provided to members, including all benefits and limitations;
  - Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the HMO) and circumstances under which services may be denied; and
  - The procedures to be followed when obtaining services and the procedures available for the review of claims for services that are denied in whole or in part.

For a list of the HMOs offered by Citi, HMO information sheets, and the Certificate of Insurance for each HMO, see "2010 insured HMOs" on page 64. The HMOs available to you will depend on your home zip code.

It is important to understand that Citi is offering only the opportunity to join an insured HMO. The actual coverage provided by the HMO is the HMO's responsibility. Citi does not guarantee or have any responsibility for the quality of health care or service provided or arranged by the HMO. Citi is not responsible for medical expenses that are not covered services under the HMO. HMO participants have the right to choose their own health care professionals and the services they receive under the HMO.

Be sure to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

If you have questions about coverage, providers, or using an HMO, please call the HMO directly at the telephone number on the HMO information sheet. This number can also be found on your HMO ID card, if you are a member of that HMO.

All the materials described above make up the Plan document for Citi's fully insured HMOs. The Plan document is intended to comply with the requirements of ERISA and other applicable laws and regulations. This HMO Plan document does not create a contract or guarantee of employment between Citi and any individual.

Typical plan design features of a Citi HMO

You must use network providers. If you do not use participating providers — except in an emergency — the HMO will not cover that care, and you will be responsible for paying the full cost of that care.

You must choose a primary care physician (PCP) before obtaining any medical services.

Your deductible is $500/individual and $1,000/family maximum. After meeting your deductible, the Plan will pay covered services at 90% while you will pay 10% (your coinsurance). Your annual out–of-pocket maximum is $3,000/individual and $6,000/family maximum.

Each HMO offers prescription drug coverage. Contact the HMO for the name of the prescription drug benefits manager.

Preventive care is covered at 100% without having to meet the deductible.

Routine vision exams are covered at 100% in all HMOs except Coventry Health Care of Iowa, Health Plan Hawaii Plus (HMSA), and Kaiser Hawaii.

As a reminder, benefits vary depending on the HMO.

You can find out more information about the specific benefits for each HMO by reviewing the HMO information sheet and the Certificate of Insurance. Call your HMO for more information.

If you have questions or concerns about specific covered services, you can contact the HMO directly or call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Primary care physician (PCPs)

In general, as a participant in an HMO, your primary care physician (PCP) provides and coordinates all of your network care. In most cases, if you need to visit a specialist, your PCP will refer you to network specialists and facilities. Consult your PCP whenever you have questions about your health.

Many HMOs will require each covered family member to select a primary care physician. You will find PCPs listed in the HMO's provider directory, which you can access by linking to the HMO information sheet available under "Fully insured health maintenance organizations (HMOs)" on page 61, then clicking on the link to the HMO's website. Generally, if you do not choose a PCP, one will be selected for you.

Your options for choosing a PCP depend on the HMO you select. For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician as your children's PCP. In some HMOs, women may select a gynecologist for their routine gynecological checkups in addition to choosing a PCP for other health care needs.

Specialists

When you need a specialist, most HMOs will require you to obtain a referral from your HMO or the services will not be covered. With most HMOs, your PCP is responsible for providing these specialist referrals. Certain services may require both a referral from your PCP and prior authorization from your HMO. Your PCP may help to coordinate any required authorizations.

If your HMO requires a referral and you visit a specialist without one, you may be responsible for the full cost of your care. Generally, you cannot request referrals after you have received the care, except in emergencies. You should contact the HMO directly or refer to the HMO's Certificate of Insurance for a detailed explanation of the referral procedures.

Routine care

Most HMOs cover preventive care services and health screenings. Such services may include:

- Routine physical exams, including well-child care and adult care;
- Routine health screenings, including gynecological exams, mammograms, sigmoidoscopy, colonoscopy, and PSA (prostatic-specific antigen) screenings;
- Routine eye exams; and
- Routine hearing exams.

Hospital care

Generally, hospital care — both inpatient and outpatient — requires a copayment or coinsurance. If you use a network provider or lab, but are not referred by your HMO, you may be required to pay for the services. Generally, hospital services require advance approval from the HMO. Your PCP may help to coordinate the approval.

See the HMO information sheet and Certificate of Insurance for more information about hospital coverage.

Maternity care

Most HMOs cover physician and hospital care for both the mother and the newborn child, including prenatal care, delivery, and post-natal care. Generally, you will need a referral for your first visit to a participating obstetrician. However, you will not need a referral for the remaining visits during your pregnancy.

The mother and the newborn child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery and 96 hours following a cesarean section. Some HMOs provide coverage for home health care visits if your doctor determines that you and your child may be safely discharged after a shorter stay.

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. See the HMO information sheet and Certificate of Insurance for more information about maternity coverage.

Call the Citi Benefits Center through ConnectOne within 31 days to add your newborn child to your coverage. The health Plans will not cover the child after 31 days. Call 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Emergency care

Benefits are always available in a medical emergency, whether you use network or out of network providers. A medical emergency is generally defined as a sickness or injury that, without immediate medical attention, could place a person's life in danger or cause serious harm to bodily functions.

If you have a true medical emergency, you should go to the nearest emergency facility. Most HMOs require you to contact your PCP or the HMO within certain time limits, generally 48 hours. If you are unable to do this, you should have a family member contact your HMO.

Most HMOs require a copayment for each emergency room visit. If you are admitted to the hospital, the copayment is generally waived. Non-emergency services provided in an emergency room are not covered.

See the HMO information sheet and Certificate of Insurance for more information, including your HMO's definition of a true medical emergency.

Benefit limits

Covered services, exclusion, and limitations vary by HMO. Check with the HMO prior to enrolling to ensure that you fully understand the provisions of the HMO.

The following HMOs limit the benefit payable per lifetime for each covered individual:

- Coventry Health Care of Iowa $2 million and
- SelectHealth (formerly IHC Health Plans), $2.5 million.

2010 insured HMOs

The following fully insured HMOs are offered by Citi for 2010 in each state. The inclusion of an HMO in a state list does not mean that the option is available throughout the state. Your home zip code determines if you are eligible to participate in one of the HMOs offered. You can determine whether the HMO is available where you live by calling the phone number on the HMO information sheet.

State	HMO
California	Kaiser FHP of California — Southern — Fact Sheet, Certificate of Insurance Kaiser FHP of California — Northern — Fact Sheet, Certificate of Insurance
Colorado	Kaiser FHP of Colorado — Fact Sheet, Certificate of Insurance
District of Columbia	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance
Georgia	Kaiser FHP of Georgia — Fact Sheet, Certificate of Insurance
Hawaii	Health Plan Hawaii Plus (HMSA) – Fact Sheet, Certificate of Insurance Kaiser FHP of Hawaii — Fact Sheet, Certificate of Insurance
Idaho	SelectHealth — Fact Sheet, Certificate of Insurance
Iowa	Coventry Health Care of Iowa — Fact Sheet, Certificate of Insurance Sanford Health Plan — Fact Sheet, Certificate of Insurance
Maryland	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance
Minnesota	Sanford Health Plan — Fact Sheet, Certificate of Insurance
New Mexico	Presbyterian Health Plan - NM — Fact Sheet, Certificate of Insurance
New York	Independent Health — Fact Sheet, Certificate of Insurance
Pennsylvania	Geisinger Health Plan — Fact Sheet, Certificate of Insurance
South Dakota	Sanford Health Plan — Fact Sheet, Certificate of Insurance
Utah	SelectHealth — Fact Sheet, Certificate of Insurance
Virginia	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance

High Deductible Health Plan - Basic and Premier

The High Deductible Health Plan (HDHP), administered by Aetna, covers the same services as ChoicePlan 500. However, there are certain major differences between the Plans.

- The HDHP provides what is referred to as “catastrophic” medical coverage. It is *not* intended for individuals who want to be reimbursed for almost all their health care expenses.
- The HDHP is designed to be used in conjunction with a Health Savings Account (HSA) in which you and/or Citi contributes pretax dollars to pay for your deductible and other eligible out-of-pocket expenses. HDHP participants are permitted to enroll in the Limited Purpose Health Care Spending Account (LPSA). Participants cannot enroll in the Health Care Spending Account (HCSA). *Enrollment in an HCSA during the plan year disqualifies participants from making HSA contributions.*
- Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.

When you enroll in an HDHP, you must be prepared to spend up to several thousand dollars out of pocket before the Plan will pay benefits, other than for certain preventive services/medications and cancer screenings. Generally, benefits cannot be paid from the HDHP until you meet the deductible.

Note: If enrolled in any of the family coverage categories (any category other than Employee Only), the entire family deductible amount must be met before the Plan will pay benefits. The out-of-pocket maximum also applies to all covered participants, not to any individual.

The HDHP-Basic has a higher deductible but costs less per pay period than the HDHP-Premier. Since the Premier option has a lower deductible, it will reimburse you for eligible expenses sooner.

High Deductible Health Plan features

- Most covered network expenses are reimbursed at 80% (Basic) and 90% (Premier) of negotiated charges after the annual deductible has been met. Claims submitted by an out-of-network provider generally are reimbursed at 70% of reasonable and customary charges after the deductible has been met.
- Routine physical exams for adults and children and well-woman exams are covered at 100% when using network providers and 100% of reasonable and customary charges when using out-of-network providers with no deductible to meet.
- Cancer screenings are covered at 100% when using network providers and 100% of reasonable and customary charges when using out-of-network providers with no deductible to meet. Cancer screening tests are the PAP smear, mammography, sigmoidoscopy, colonoscopy, and PSA test.
- Prescription drugs are covered by the Citigroup Prescription Drug Program administered by Express Scripts. You first must meet your combined medical and prescription drug deductible before you can purchase prescription drugs at a retail network pharmacy and through the Express Scripts Home Delivery program for the Plan's copayment or coinsurance, except as described in the bullet immediately below.
- You can purchase certain preventive-care medications for a copayment or coinsurance *before* the deductible is met. Copayments/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the Express Scripts' website. If you are a participant in a medical Plan with prescription drug coverage through Express Scripts, visit **www.express-scripts.com**. If not, visit **https://member.express-scripts.com/preview/citigroup2010**.
- The Plan has no lifetime maximum benefit other than for infertility coverage.

Citi has determined that the HDHP does not constitute "creditable coverage" under Medicare. If you enroll in the HDHP and become eligible for Medicare in the same plan year, you may pay more for Medicare Part D prescription drug coverage if you later choose to elect it. For information about creditable coverage, see the Non-Creditable Coverage Disclosure Notice.

HIGH DEDUCTIBLE HEALTH PLAN AT A GLANCE				
	HIGH DEDUCTIBLE HEALTH PLAN - PREMIER		HIGH DEDUCTIBLE HEALTH PLAN - BASIC	
	Network	Out of network	Network	Out of network
Company contribution to your HSA	$500 Employee Only/ $1,000 all other coverage categories		$500 Employee Only/ $1,000 all other coverage categories	
Deductible	$1,200/$2,400	$2,400/$4,800	$2,100/$4,200	$3,100/$6,200
Out-of-pocket maximum (including deductible)	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	$7,500/$15,000
Coinsurance	90%	70%	80%	70%
Prescription drug coverage for generic, preferred, and non-preferred medications				
Retail	$5/$30/50% up to a $50 minimum/$150 maximum after the annual deductible has been met	Covered at 50% after the annual deductible has been met	$5/$30/50% up to a $50 minimum/$150 maximum after the annual deductible has been met	Covered at 50% after the annual deductible has been met
Mail order	$12.50/$75/50% up to a $125 minimum/ $375 maximum after the annual deductible has been met	Not applicable	$12.50/$75/50% up to a $125 minimum/ $375 maximum after the annual deductible has been met	Not applicable

Aetna High Deductible Health Plans – Basic

Type of service	Network	Out of Network
Annual deductible (includes prescription drug expenses)		
• Single	• $2,100	• $3,100
• Family	• $4,200	• $6,200
Annual out-of-pocket maximum (includes deductible)		
• Single	• $5,000	• $7,500
• Family	• $10,000	• $15,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP or specialist visits	• 80% after deductible	• 70% of R&C after deductible
• Allergy treatment	• 80% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of R&C after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100% no deductible	• 100% of R&C, no deductible
Routine care (subject to frequency limits)		
• Routine vision exam	• 100%, no deductible; limit 1 exam per 24 months	• 100% of R&C, no deductible; limit 1 exam per 24 months
• Routine hearing exam	• 100%, no deductible; limit 1 exam per 24 months	• 100% of R&C, no deductible; limit 1 exam per 24 months
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, and surgical care	• 80% after deductible; precertification required for hospitalization and certain outpatient procedures and services	• 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures and services
Maternity care		
• Physician office visit	• 80% after deductible	• 70% of R&C after deductible
• Hospital delivery	• 80% after deductible	• 70% of R&C after deductible
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room • (includes emergency room facility and professional services provided in the emergency room)	• 80% of covered services after deductible; precertification required if admitted	• 80% of covered services after deductible; precertification required if admitted
• Urgent care facility	• 80% of covered services after deductible	• 80% of covered services after deductible
• Non-routine outpatient lab and X-ray services	• 80% of covered services after deductible	• 70% of covered services after deductible
Outpatient short-term rehabilitation		
Physical, speech, or occupational therapy	• 80% after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy • 70% after deductible for visits approved for medical necessity above the limit.	• 70% of covered services after deductible • 60 visits per year for physical, speech, developmental, and occupational therapy • 50% of R&C after deductible for visits approved for medical necessity above the limit.
Prescription drugs (refer to *Prescription Drugs* section)		
Mental health and chemical dependency (refer to ""Mental health/chemical dependency" on page 68)		

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see “Covered services and supplies” on page 78 and “Exclusions and limitations” on page 89.

How the Plan works

This section contains more detailed information about HDHP’s provisions and how this medical plan option works.

You have a choice of using network providers or out of network providers. Using network providers saves you money in two ways. First, network providers charge special, negotiated rates, which are generally lower than the R&C amounts. Second, the level of reimbursement for many services is higher when you use a network provider.

A directory of network providers is available directly from the Claims Administrator.

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call 1-800-545-5862

Deductible and coinsurance

You must meet an annual deductible of $2,100 for individual (employee only) coverage or $4,200 for family (employee plus one or more) before the Aetna High Deductible Health Plan (HDHP) Basic pays any benefits, unless the service is covered at 100%, such as preventive care.

The deductible applies to all covered expenses except preventive care and must be satisfied each calendar year before any benefits will be paid.

- Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the Plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:
- **Employee Only:** The individual deductible of $2,100 applies.
- **Two or more in a family:** The $4,200 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.

Once you have satisfied the deductible, HDHP Basic normally pays 80% of the negotiated rate for covered health services if you or your covered dependent uses a network hospital/provider. Expenses are normally reimbursed at 70% of R&C for claims for covered services submitted for an out of network provider.

Out-of-pocket maximum

Your out-of-pocket maximum is $5,000 individual/$10,000 family (out of network $7,500/individual and $15,000/family). The amount includes the $2,100/individual and $4,200/family (out of network $3,100/$6,200) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Only covered expenses count toward the individual or family out-of-pocket maximum. There is no individual within the family out-of-pocket maximum. One family member or a combination of family members must meet the full family out-of-pocket maximum and the maximum can be met as follows:

- Employee Only: $5,000 (out of network $7,500)
- Two or more in a family: the $10,000 (out of network $15,000) family out-of-pocket maximum applies; one or a combination of all family members must meet the full family out-of-pocket maximum

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate (or of R&C amounts) for the remainder of the calendar year. However, the plan does not cover the amount over R&C. You can still be billed for that amount and are responsible for paying that portion.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed R&C charges, charges for services not covered under the Plan, and any expense that would have been reimbursed if you had followed the notification requirements for care.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% when using network providers or 100% of R&C when using out-of-network providers.

Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient’s provider at a

frequency based on American Medical Association guidelines or as directed by the provider. For frequency guidelines, call the Claim Administrator;

- Routine diagnostic tests. For example: CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.
- In addition, the HDHP Basic will cover cancer-screening tests, well-adult immunizations and well-child care and immunizations at 100%.

Cancer screenings are:

- Pap smear performed annually;
- Mammogram at a frequency based on age:
  - Ages 35–39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Routine care

Routine health screenings are covered at:

- 100%, no deductible and
- 100% of the reasonable and customary (R&C) charges, no deductible (for care received from an out of network provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine vision exam:** limited to one exam per 24 months and
- **Routine hearing exam:** limited to one exam per 24 months.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% for care received from an in-network provider; or
- 70% for care received from an out-of-network provider.

Notification of an inpatient admission is required. Notification is recommended for certain outpatient procedures and services.

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at:

- 80% for care received from an in-network or out-of-network provider.

Non-emergency services provided in an emergency room are not covered.

Urgent care

Urgent care centers will be reimbursed at:

- 80% of the negotiated rate (after deductible is met) for care received from an in-network provider; or
- 70% of R&C (after deductible is met) for care received from an out-of-network provider.

Mental health/chemical dependency

Aetna HDHP Basic provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 80% of negotiated rate; precertification required
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; precertification required	After the deductible, eligible expenses covered at 70% of R&C; precertification required

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under Aetna HDHP Basic.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment:
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

You *must* call the Claims Administrator to give notification of inpatient services. Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 80% of the negotiated rate when you use a network provider or 70% of R&C if you use an out of network provider. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Outpatient services

You are encouraged to call the Claims Administrator for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of R&C for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral; however you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The behavioral health provider is available 24/7 hours a day, seven days a week to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. Please refer to the “Glossary” for a definition of medical necessity.

For more information about what your Plan covers, see “Covered services and supplies” on page 78. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Aetna High Deductible Health Plans – Premier

Type of service	Network	Out of network
Annual deductible (includes prescription drug expenses)		
• Single • Family	• $1,200 • $2,400	• $2,400 • $4,800
Annual out-of-pocket maximum (includes deductible)		
• Single • Family	• $2,500 • $5,000	• $5,000 • $10,000
Lifetime maximum	• None	• None
Professional care (in office)		
• PCP or specialist visits	• 90% after deductible	• 70% of R&C after deductible
• Allergy treatment	• 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	• 70% of R&C after deductible
Preventive care (subject to frequency limits)		
• Well-adult visits and routine immunizations • Well-child visits and routine immunizations • Cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	• 100%, no deductible	• 100% of R&C, no deductible
Routine care (subject to frequency limits)		
• Routine vision exam	• 100%, no deductible; limit 1 exam per 24 months	• 100% of R&C, no deductible; limit 1 exam per 24 months
• Routine hearing exam	• 100%, no deductible; limit 1 exam per 24 months	• 100% of R&C, no deductible; limit 1 exam per 24 months
Hospital inpatient and outpatient		
• Semiprivate room and board, doctor's charges, lab, X-ray, and surgical care	• 90% after deductible; precertification required for hospitalization and certain outpatient procedures and services	• 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures and services
Maternity care		
• Physician office visit	• 90% after deductible	• 70% of R&C after deductible
• Hospital delivery	• 90% after deductible	• 70% of R&C after deductible
Emergency care (no coverage if not a true emergency)		
• Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	• 90% of covered services after deductible; precertification required if admitted	• 90% of covered services after deductible; precertification if admitted
• Urgent care facility	• 90% of covered services after deductible	• 90% of R&C of covered services after deductible
Non-routine outpatient lab and X-ray services	• 90% of covered services after deductible	• 70% of R&C of covered services after deductible
Outpatient short-term rehabilitation		
• Physical, speech, or occupational therapy	• 90% after deductible • 60 visits per year for physical, speech, developmental and occupational • 70% after deductible for visits approved for medical necessity above the limit.	• 70% of R&C covered services after deductible • 60 visits per year for physical, speech, developmental and occupational • 50% of R&C after deductible for visits approved for medical necessity above the limit.
Prescription drugs (refer to *Prescription Drugs* section)		
Mental health and chemical dependency (refer to "Mental health/chemical dependency" on page 72)		

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see “Covered services and supplies” on page 78 and “Exclusions and limitations” on page 89.

How the Plan works

This section contains more detailed information about HDHP’s provisions and how this medical plan option works.

You have a choice of using network providers or out of network providers. Using network providers saves you money in two ways. First, network providers charge special, negotiated rates, which are generally lower than the R&C amounts. Second, the level of reimbursement for many services is higher when you use a network provider.

A directory of network providers is available directly from the Claims Administrator.

- Aetna: **www.aetna.com**, select the Aetna Open Access, Choice POSII Open Access Plan or call 1-800-545-5862

Deductible and coinsurance

You must meet an annual deductible of $1,200 for individual (employee only) coverage or $2,400 for family (employee plus one or more) before Aetna High Deductible Health Plan (HDHP) Premier pays any benefits, unless the service is covered at 100%, such as preventive care.

The deductible applies to all covered expenses except preventive care and must be satisfied each calendar year before any benefits will be paid.

- Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the Plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:
- **Employee only:** The individual deductible of $1,200 applies.
- **Two or more in a family:** The $2,400 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.

Out-of-pocket maximum

Your out-of-pocket maximum is $2,500 individual/$5,000 family (out of network $5,000 individual/$10,000 family). The amount includes the $1,200 individual/$2,400 family (out of network $2,400 individual/$4,800 family) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Eligible expenses can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($2,500/5,000 out of network) to the family out-of-pocket maximum ($5,000/10,000 out of network).

Only covered expenses count toward the individual or family out-of-pocket maximum. There is no individual within the family out-of-pocket maximum. One family member or a combination of family members must meet the full family out-of-pocket maximum and the maximum can be met as follows:

- Employee only: $2,500 (out of network $5,000)
- Two or more in a family: the $5,000 (out of network $10,000) family out-of-pocket maximum applies; one or a combination of all family members must meet the full family out-of-pocket maximum

Example: If in two or more family coverage tier, one family member or a combination of family members must meet the full family out-of-pocket maximum ($10,000) before the Plan pays 100% of any benefits.

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate (or of R&C) for the remainder of the calendar year.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed R&C, charges for services not covered under the Plan, and any expense that would have been reimbursed if you had followed the notification requirements for care.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% of negotiated rates when using network providers or 100% of R&C when using out-of-network providers.

Preventive care services include:

- Routine physical exams: well-child care and adult care, performed by the patient's provider at a frequency based on American Medical Association guidelines or as directed by the provider. For frequency guidelines, call the Claim Administrator;
- Routine diagnostic tests. For example: CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.
- In addition, the HDHP Premier will cover cancer-screening tests, well-adult immunizations and well-child care and immunizations at 100%.

Cancer screenings are:

- Pap smear performed annually;
- Mammogram at a frequency based on age:
  - Ages 35–39: baseline mammogram; or
  - Age 40 and older: annual mammogram;
- Sigmoidoscopy annually for persons age 50 and older;
- Colonoscopy; and
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Routine care

Routine health screenings are covered at:

- 100%, no deductible, and
- 100% of the reasonable and customary (R&C) charges, no deductible (for care received from an out of network provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine vision exam:** limited to one exam per 24 months
- **Routine hearing exam:** limited to one exam per 24 months
- To be sure your claim for a routine exam is paid properly, ask your physician to indicate "routine exam" on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked "routine exam."

Mental health/chemical dependency

Aetna HDHP Premier provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claims Administrator at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call before seeking treatment for mental health or chemical dependency treatment.

Action (all visits are reviewed for medical necessity)	Inpatient	Outpatient
If you call the Plan and use its network provider/facility	After the deductible, eligible expenses covered at 90% of the negotiated rate; precertification required	After the deductible, eligible expenses covered at 90% of negotiated rate; precertification required
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; precertification required	After the deductible, eligible expenses covered at 70% of R&C; precertification required

Note: Mental health and chemical dependency maximums are combined.

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations, and deductibles that are required under Aetna HDHP Premier.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

You *must* call the Claims Administrator to give notification of inpatient services. Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 90% when you use a network provider or 70% of R&C if you use an out of network provider. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the Claims Administrator in advance of the admission.

Outpatient services

You are encouraged to call the Claims Administrator for outpatient referrals. If you call and use the recommended provider, you will be reimbursed at 90% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 70% of R&C for covered services after the deductible is met.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral, however you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The behavioral health provider is available 24/7 hours a day, seven days a week to accept calls.

Medically necessary

The Claims Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claims Administrator will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the Claims Administrator determines that the covered services and supplies are medically necessary. Please refer to the “Glossary” for a definition of medical necessity.

For more information about what your Plan covers, see “Covered services and supplies” on page 78. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Health Savings Accounts (HSAs)

An HSA is used in conjunction with a qualified High Deductible Health Plan, such as the Basic and Premier Plans offered by Citi.

When you enroll in either High Deductible Health Plan, you are eligible to open an HSA through any bank or institution that offers one. HSAs were designed to work with HDHPs to help you:

- Pay for expenses incurred before you meet your deductible;
- Pay for qualified medical expenses that are not otherwise reimbursable by the HDHP; and
- Save for future qualified medical and retiree health expenses on a tax-free basis.

To establish an HSA, you must be covered by a High Deductible Health Plan, and you cannot be enrolled in “impermissible medical care coverage,” such as a Health Care Spending Account, any other medical coverage, or Medicare or receive Social Security benefits.

You may visit Citi’s on-site medical clinics for preventive care and allergy injections (if you supply the allergy medication)/visits; to obtain non-prescription pain relievers; and as a result of an accident at work. If enrolled in a Health Savings Account, you may *not* use Citi’s on-site medical clinics for treatment when sick. Use of on-site medical clinics for other reasons, such as sick care, would be considered “impermissible medical coverage.”

If you enroll in the High Deductible Health Plan-Basic or Premier for 2010 and accept the terms of an HSA, through Your Benefits Resources™ Citi will contribute to your account. The annual contribution amounts are up to $500 for Employee Only coverage and up to $1,000 for any of the other coverage categories.

The maximums that can be contributed to an HSA for 2010 are:

- $3,050 for an eligible individual with Employee Only coverage and
- $6,150 for an eligible individual enrolling in any other coverage category.

Under federal law, individuals who are 55 or older by December 31, 2010, can make a catch-up contribution of an additional $1,000 for 2010 and each year going forward.

If you do not enroll in a High Deductible Health Plan, by law you cannot establish a Health Savings Account.

Funds are available in the HSA once they have been contributed, not sooner like with an HCSA.

Health Savings Account features

- You "own" your HSA; your account is portable.
- Contributions to an HSA can be made by individuals, employers, or both.
- Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.
- Withdrawals (to pay for qualified medical expenses, as determined by the IRS) are tax-free under federal and many state income tax laws.
- You do not forfeit funds that you do not use by year-end. Instead, HSA funds remaining in your account will roll over to the following year.

Note: The HSA is not part of the Citigroup Health Benefit Plan or any other employee benefit plan sponsored by Citi.

HSA and the LPSA

If you enroll in a High Deductible Health Plan and make tax-free contributions to an HSA you cannot participate in a Health Care Spending Account (HCSA). *HCSA enrollment is considered "impermissible medical care coverage" and disqualifies your contributions to an HSA.*

According to IRS regulations, if you enroll in a High Deductible Health Plan you can enroll in the Limited Purpose Health Care Spending Account (LPSA) to reimburse yourself for eligible expenses such as those for vision, dental, and preventive medical care. You also may enroll in an LPSA if you enrolled in an HDHP but are not enrolled in an HSA.

An LPSA works like an HCSA, except only certain types of expenses are eligible for reimbursement. See the "LPSA" section in the *Spending Accounts* section for more information.

For more information about the LPSA, contact your tax adviser or visit the IRS website at **www.irs.gov**. From the home page, go to the search feature at the top of the page and enter "Ruling 2004-45."

Hawaii Health Plan (Hawaii only)

Hawaii Health Plan is available in Hawaii only and is administered by UnitedHealthcare. You can save money by using UnitedHealthcare's preferred providers. This Plan is in compliance with the Prepaid Health Care Act and is effective on date of hire. Eligible employees are all employees (including, but not limited to, full-time, part-time, temporary, on-call, and seasonal workers) who work at least 20 hours each week for four consecutive weeks. Full medical coverage will be continued for a disabled employee for three months following the month of disability.

For the names of network providers, visit **www.myuhc.com/groups/citi** or call 1-877-311-7845. When prompted to choose a network, choose "Choice Plus Plan."

Hawaii Health Plan at a Glance

Type of service	Hawaii Health Plan (UnitedHealthcare available in Hawaii only)
Annual deductible	
• Individual	• $200
• Maximum per family	• $600
Annual out-of-pocket maximum (includes deductible)	
• Individual	• $1,000
• Maximum per family	• $2,000
Lifetime maximum	• $3 million
Professional care (in office)	
• PCP or specialist visits	• 90% after deductible when using network providers; 80% of R&C after deductible when using out of network providers
Routine care (subject to frequency limits)	
• Well-adult visits and routine immunizations	• 80%, no deductible
• Well-child visits and routine immunizations	• 80%, no deductible
Hospital inpatient and outpatient	
• Semiprivate room and board, doctor's charges, lab, X-ray, and surgical care	• Inpatient: 90% after deductible when using network physicians; 80% of R&C after deductible when using network hospital; 80% after deductible when using out of network physicians; 80% of R&C after $100 confinement deductible and calendar year deductible when using out of network hospitals; notification required for hospitalization and certain outpatient procedures • Outpatient: 90% after deductible when using network physician; 80% of R&C after deductible when using out of network physician; 80% of R&C after deductible for hospital
Emergency care	
• No coverage if not a true emergency	• 90% after deductible for physician; 80% after deductible for hospital
Urgent care center	• 90% after deductible when using network providers; 80% of R&C after deductible when using out of network providers
Prescription drugs (refer to *Prescription Drugs* section)	
Mental health and chemical dependency (refer to "Mental health/chemical dependency" on page 77	

This table is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 78 and "Exclusions and limitations" on page 89**.**

How the Plan works

This section contains more detailed information about Hawaii Health Plan's provisions and how the Plan works.

You have a choice of using preferred providers or non-preferred providers. Using preferred providers saves you money in two ways. First, preferred providers charge negotiated rates, which are generally lower than the R&C charges. Second, the level of benefits is generally higher when you use a preferred provider.

A directory of preferred providers is available directly from UnitedHealthcare at 1-877-311-7845 or online. The directory can be found online at **www.myuhc.com/groups/citi**.

For information about how to file a claim or appeal a denied claim, "Claims and appeals for UnitedHealthcare medical plans" on page 96.

Deductibles and coinsurance

You must meet an annual deductible of $200 individual ($600 family maximum) before the Hawaii Health Plan pays any benefits. There is no annual deductible for routine preventive care.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible is the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible count toward the family deductible. The family deductible can be met as follows:

- **Up to two in a family:** each member must meet the $200 individual deductible; or
- **Three or more in a family:** expenses can be combined to meet the $600 family deductible, but no one person can apply more than the $200 individual deductible toward the family deductible amount.

Once you have satisfied the deductible, Hawaii Health Plan normally pays 90% of the negotiated rate for covered health services if you or your covered dependent uses a UnitedHealthcare preferred physician, and pays 80% of R&C if you use a UnitedHealthcare preferred hospital.

Out-of-pocket maximum

Your individual out-of-pocket maximum is $1,000 ($2,000 family maximum). The amount includes the $200 individual ($600 family) deductible. There is a lifetime maximum of $3 million. Once this out-of-pocket maximum is met, covered expenses are payable for the remainder of the calendar year at 100% of the negotiated rate when you use a preferred provider or at 100% of R&C when you use a non-preferred provider.

Eligible expenses can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket maximum amount ($1,000) to the family out-of-pocket maximum ($2,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed R&C, pharmacy copayments, and penalties applied for failure to notify UnitedHealthcare. Mental health/chemical dependency treatment expenses, including copayments, count toward your calendar-year, out-of-pocket maximum and the Stop-Loss provision.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); and
- 80% of R&C (for care received from a non-preferred provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines. For frequency guidelines, call UnitedHealthcare at 1-877-311-7845;
- **Routine cancer screenings are limited to:**
  - Annual Pap smear;
  - Mammogram at a frequency based on age:
    - Ages 35–39: baseline mammogram; or
    - Age 40 and older: annual mammogram;
  - Sigmoidoscopy annually for persons age 50 and older;
  - Colonoscopy (covered as part of a routine physical); and
  - Prostatic-specific antigen (PSA) screening.

All routine care is covered at 80% of the negotiated rate for preferred providers or 80% of R&C for non-preferred providers. There is no deductible or annual maximum for routine physicals.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate "routine exam" on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked "routine exam."

For more specific information, contact UnitedHealthcare directly.

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% of the negotiated rate for claims incurred at a UnitedHealthcare preferred hospital; and
- 80% of R&C after the $100 per confinement deductible for claims incurred at a non-preferred hospital in an area where one was available.

Emergency care

After you satisfy the deductible, emergency care is covered at 80% for covered hospital services and 90% for covered physician services. Non-emergency services provided in an emergency room are not covered.

See the *Glossary* for the definition and examples of emergency care as defined and determined by the Plan.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact UnitedHealthcare within 48 hours. See "Precertification/ notification" on page 42. If you are not able to do this, have a family member contact UnitedHealthcare. Penalty for non-compliance is $400 per admission (to a maximum penalty, in the aggregate, of $1,000 per calendar year).

Mental health/chemical dependency

Hawaii Health Plan provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call UnitedHealthcare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right care provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call UnitedHealthcare before seeking treatment for mental health or chemical dependency treatment. For more information, see "Precertification/ notification" on page 42.

Information regarding participating providers is available directly from UnitedHealthcare at 1-877-311-7845 or online at **www.liveandworkwell.com**; access code Citi.

Action	Inpatient	Outpatient
If you call UnitedHealthcare and use its network provider/facility	After the deductible, eligible physician expenses covered at 90% of the negotiated rate and eligible hospital expenses covered at 80% of the negotiated rate	After the deductible, eligible expenses covered at 90% of R&C
If you call UnitedHealthcare but do not use its network provider/facility	After a $100 confinement deductible and after the $200 individual deductible, eligible expenses covered at 80% of R&C	After the deductible, eligible expenses covered at 80% of R&C
If you do not call and do not use UnitedHealthcare's network provider/facility	$400 non-notification penalty per admission, up to a maximum penalty of $1,000 per calendar year; after a $100 confinement deductible and the $200 deductible, eligible expenses covered at 80% of R&C	After the deductible, eligible expenses covered at 80% of R&C

Coverage levels

Unlike the medical benefits under Hawaii Health Plan, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage guidelines and deductibles that are required under Hawaii Health Plan.

Mental Health benefits include, but are not limited to:

- Assessment, diagnosis, treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient;
- Partial hospitalization programs;
- Facility based intensive outpatient program services; and
- Psychological testing that is not primarily educational in nature.

No benefit will be paid for services that are not considered to be medically necessary.

Inpatient services

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. Inpatient mental health/substance abuse treatment is covered at least 80%. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state is which the patient resides, unless approved by UnitedHealthcare in advance of the admission.

Outpatient services

You are encouraged to call UnitedHealthcare for outpatient referrals, although a referral is not required. If you call UnitedHealthcare and use network providers, you will be reimbursed for 80% of the negotiated rates per visit after the deductible is met. If you do not use UnitedHealthcare's recommended providers, you will be reimbursed for 80% of R&C for covered services after the deductible is met.

Emergency care

Emergency care does not require a referral from UnitedHealthcare. When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call UnitedHealthcare within 48 hours after the emergency care is given. UnitedHealthcare's behavioral health provider is available 24/7 hours a day, seven days a week to accept calls.

When emergency care has ended, you should call UnitedHealthcare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights table.

Medically necessary — mental health/chemical dependency benefits

UnitedHealthcare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. UnitedHealthcare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless UnitedHealthcare's behavioral health provider determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" for a definition of medical necessity.

For more information about coverage for a particular service or supply or limits that may apply, see "Covered services and supplies" on page 78 or call UnitedHealthcare at 1-877-311-7845.

Note: Benefits details stated in the Hawaii Health Plan section are subject to approval by the Hawaii DOL.

Covered services and supplies

This list of covered services and supplies applies to all non-HMO and Oxford PPO Health Plans sponsored by Citi, except where noted.

Covered services and supplies must be medically necessary and related to the diagnosis or treatment of an accidental injury, sickness, or pregnancy. Reimbursement for all covered services and supplies listed in this section are subject to reasonable and customary (R&C) or, for network services, the negotiated rates of the Plan.

You and your physician decide which services and supplies are required, but the Plan pays only for the following covered services and supplies that are medically necessary as determined by the Claims Administrators.

Covered services and supplies also include services and supplies that are part of a case management program. A case management program is a course of treatment developed by the Claims Administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless the case management program specifies otherwise, the provisions of the Plan related to benefit amounts, maximum amounts, copayments, and deductibles will apply to these services.

Acupuncture

Must be administered by a medical doctor or a licensed acupuncturist.

Adult immunizations

The following are the guidelines for covered adult immunizations:

- **Tetanus, diphtheria (Td):** Booster every 10 years;
- **Influenza (flu):** Annual for adults under age 50 and at risk; annual for adults age 50 plus;
- **Pneumococcal vaccine (PPV):** Once for adults under age 50 with risk factors with booster after five years for adults at highest risk and those most likely to lose their immunity; once at age 65 with booster after five years if <65 at time of primary vaccination;
- **Varicella (chicken pox):** Persons under age 50 with no history of varicella and who test negative for immunity. Persons over age 50, assume immunity. **Note:** Women who are pregnant (or planning to become pregnant in the next four weeks) should NOT be vaccinated;
- **Measles, mumps, rubella (MMR):** People born after 1956 - two doses measles with additional doses as MMR; people born before 1957 can be considered immune. **Note:** Women who are pregnant (or planning to become pregnant in the next four weeks) and people whose immune system is not working properly should NOT be vaccinated;
- **Hepatitis A:** Only those at risk; those at risk, two doses at least six months apart;
- **Hepatitis B:** Immunize if age 46 or under; if over age 45, only those at high risk; if at risk, three doses (second dose one to two months after the first dose, and the third dose no earlier than two months after the first dose and four months after the second dose);
- **Meningococcal:** Meningitis - only those at risk; if at increased risk, one dose (an additional dose may be recommended for those who remain at high risk);
- **Tuberculin Skin Test:** Annual testing for high-risk group (method: five tuberculin units of PPD);
- **Gardasil vaccine for HPV:** Females age 9 years to 26 years of age; and
- **Zostavax vaccine for shingles:** Adults age 60 or older.

Ambulatory surgical center

A center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Drugs that produce loss of feeling or sensation either generally or locally, except when done for dental care not covered by the Plan.

Anesthesia is not covered when rendered in the doctor's office or when administered by the operating surgeon.

Baby care

The following services and supplies given during an eligible newborn child's initial hospital confinement:

- Hospital services for nursery care;
- Other services and supplies given by the hospital;
- Services of a surgeon for circumcision in the hospital; and
- Physician services.

Birth center

Room and board and other services, supplies, and anesthetics.

Cancer detection

Diagnostic screenings not subject to precertification or notification include:

- Mammogram;
- Pap smear;
- Prostatic-specific antigen (PSA);
- Sigmoidoscopy; and
- Colonoscopy.

Chemotherapy

For cancer treatment.

Contraceptive services/devices

Contraceptive services and devices, including but not limited to:

- Diaphragm and intrauterine device and related physician services;
- Voluntary sterilization by either vasectomy or tubal ligation;
- Injectables such as Depo-Provera; and
- Surgical implants for contraception, such as Norplant.

Dietitian/nutritionist

Nutritional counseling is covered by a licensed dietitian and/or licensed nutritionist for diabetes, bulimia, anorexia nervosa, and morbid obesity only.

Durable medical equipment

Durable medical equipment means equipment that meets all of the following:

- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired organ or part;
- Orthotic devices such as arm, leg, neck, and back braces;
- Hospital-type beds;
- Equipment needed to increase mobility, such as a wheelchair;
- Respirators or other equipment for the use of oxygen; and
- Monitoring devices (e.g., blood glucose monitor).

Each Claims Administrator decides whether to cover the purchase or rental of the equipment based on coverage guidelines. Changes made to your home, automobile, or personal property are not covered. Rental coverage is limited to the purchase price of the durable medical equipment. Replacement, repair, and maintenance are covered only if:

- They are needed due to a change in your physical condition or
- It is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

Foot care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses; the cutting and trimming of toenails; and foot care for flat feet, fallen arches, and chronic foot strain is a covered service only if needed due to severe systemic disease.

- **Aetna and Empire BlueCross BlueShield ChoicePlan 500** cover the services of a podiatrist for the treatment of a disease or injury, including the treatment of corns, calluses, keratoses, bunions, and ingrown toenails.

Hearing aids

Hearing aids are covered regardless of reason for hearing loss. Hearing aid coverage for:

- Adults: Benefit is up to $1,200 once every 36 months and
- Children: Benefit is up to $1,200 every 24 months.

Home health care (combined with private-duty nursing)

The following covered services must be given by a home health care agency:

- Temporary or part-time skilled nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN)
- Medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies with the Plan that the medical social services are necessary for the treatment of your medical condition.

Covered services are limited to 200 visits each calendar year (combined visits with private-duty nursing), and you must notify the Plan in advance. Each period of home health aide care of up to eight hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit. Multiple services provided on the same day count as one visit and are billed by the same provider on the same bill. Visits may be increased with prior approval from your health Plan.

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available);
- Other services and supplies;
- Part-time nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN);
- Home health care services as shown under home health care; the limit on the number of visits shown under home health care does not apply to hospice patients;
- Counseling for the patient and covered dependents;
- Pain management and symptom control; and
- Bereavement counseling for covered dependents; services must be given within six months after the patient's death, and covered services are limited to a total of 15 visits for each family member.
  - For **Aetna ChoicePlan 500** and **Empire BlueCross BlueShield ChoicePlan 500**, bereavement counseling is covered under the mental health benefit.
  - **Oxford Health Plans** will cover up to 15 visits for supportive care and guidance, when certified as part of the program, for the purpose of helping the member and the member's immediate family cope with the emotional and social issues related to the member's condition. The member's family must also be covered under the Plan. Coverage is not provided for funeral arrangements; pastoral financial or legal counseling; or homemaker, caretaker, or respite care. If the member's contract with Oxford is terminated, no further benefits are available.

Bereavement counseling must be given by a licensed counselor. Services for the patient must be given in an inpatient hospice facility or in the patient's home. The physician must certify that the patient is terminally ill with six months or less to live. Any counseling services given in connection with a terminal illness will not be considered as mental health and chemical dependency treatment for purposes of applying the mental health/chemical dependency maximum visit limit.

Hospital services

Hospital services include:

- Room and board: Covered expenses are limited to the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate);
- Other services and supplies, including:
  - Intensive or special care facilities when medically appropriate;
  - Visits by your physician while you are confined;
  - General nursing care;
  - Surgical, medical, and obstetrical services;
  - Use of operating rooms and related facilities;
  - Medical and surgical dressings, supplies, casts, and splints;
  - Drugs and medications;
  - Intravenous injections and solutions;
  - Nuclear medicine;
  - Preoperative care and post-operative care:
    - Administration and processing of blood;
    - Anesthesia and anesthesia services;
    - Oxygen and oxygen therapy;
    - Inpatient physical and rehabilitative therapy, including cardiac and pulmonary rehabilitation;
    - X-rays, laboratory tests, and diagnostic services; and
    - Magnetic resonance imaging (MRI).

Emergency room services are covered services only if it is determined that the services are medically appropriate and there is not a less intensive or more appropriate place of service, diagnostic, or treatment alternative that could have been used in lieu of emergency room services. If your health Plan, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). Authorizations are required for longer lengths of stay.

Infertility treatment

Infertility benefits are provided by the following Plans: ChoicePlan 500, High Deductible Health Plan – Basic and Premier, and Hawaii Health Plan.

Diagnosis of infertility and surgical correction of a medical condition causing infertility are covered subject to the Plan's copayment or deductible and coinsurance.

Covered services include:

- Services for diagnosis and treatment of the underlying medical condition:
  - Initial evaluation, including history, physical exam, and laboratory studies;
  - Physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor;
  - Evaluation of ovulation function;
  - Ultrasound of ovaries;
  - Post-coital test;
  - Hysterosalpingogram;
  - Endometrial biopsy;
  - Hysteroscopy; and
  - Semen analysis for male members.
- Advanced reproductive services:
  - Ovulation induction cycle with menotropins;
  - Harvesting of Plan participant's eggs;
  - Artificial insemination;
  - Infertility surgery (diagnostic or therapeutic);
  - ART services and treatment, including in vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and cryopreserved embryo transfer and Frozen Embryo Transfer (FET);
- Medical expenses for infertility treatment are covered up to a family lifetime maximum of $24,000.
- Prescription drug expenses associated with infertility treatment are covered up to a lifetime maximum of $7,500, through the *Prescription Drugs* section.
- Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs.

The Hawaii Health Plan covers medical *and* pharmacy expenses associated with infertility treatment. The infertility benefit covers:

- Medical expenses up to a $24,000 family lifetime maximum and
- Prescription drug expenses associated with infertility treatment up to a $7,500 lifetime maximum

The Plan deductible does not apply.

Oxford PPO Health Plans: Each Oxford Health Plan offers different infertility coverage and limits, please contact your Plan for details.

HMOs: Each HMO offers different infertility coverage and limits, if at all. Check with your HMO for specific details of infertility coverage.

Laboratory tests/X-rays

X-rays or tests for diagnosis or treatment.

Licensed counselor services

Services of a licensed counselor for mental health and chemical dependency treatment.

Medical care

- Hospital, office, and home visits and
- Emergency room services.

Medical supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure and
- Blood or blood derivatives only if not donated or replaced. This means:
  - Autologous blood donation: The donation of your own blood for use during a scheduled covered surgical procedure;
  - Directed blood donation: The donation of blood by a person chosen by the patient to donate blood for the patient's use during a scheduled covered surgical procedure; and
  - Autologous or directed blood donation prior to a scheduled surgery when it generally requires blood transfusions and the provider/organization that obtains and processes the blood makes a charge that the patient is legally obligated to pay.

Medical transportation services

Transportation by professional ambulance or air ambulance to and from the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, or Canada.

- **Aetna ChoicePlan 500** and **Empire BlueCross BlueShield ChoicePlan 500** cover medical transportation services outside of these geographic areas to and from the nearest medical facility.
- **Oxford Health Plans:** When a member has traveled out of the country, emergency or 911 transportation to the nearest hospital and/or hospital emergency facility does not require notification, precertification or certification. However, Oxford Medical Management should be notified of an admission within 48 hours or as soon as possible, consistent with the member's certificate. All requests for other out-of-the-country transportation require precertification and Medical Director review.

The Health Plans cover professional ambulance service on a standard basis to transport the individual from the place where he/she is injured or stricken by disease to the first hospital where treatment is given. Ambulettes are not covered.

Morbid obesity expenses (non-HMO/PPO plans)

Covered medical expenses include charges made on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Limitations apply. For more information, contact your Plan directly.

Dietician/nutritionist coverage is also available for morbid obesity. See the "Dietitian/nutritionist" section on page 80.

Nurse-midwife

Services of a licensed or certified nurse-midwife. Maternity-related benefits are payable on the same basis as services given by a physician.

Nurse-practitioner

Services of a licensed or certified nurse-practitioner acting within the scope of that license or certification. Benefits are payable on the same basis as covered services given by a physician.

Oral surgery/dental services

The Plan pays first (the primary plan) for oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

The following oral surgeries are considered medical in nature and covered under the medical Plan as necessary:

- Treat a fracture, dislocation, or wound.

- Cut out:
  - Teeth partly or completely impacted in the bone of the jaw;
  - Teeth that will not erupt through the gum;
  - Other teeth that cannot be removed without cutting into bone;
  - The roots of a tooth without removing the entire tooth;
  - Cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is covered only when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- **Empire BlueCross BlueShield** accepts the following oral surgeries as medical in nature and covered under the medical Plan as necessary:
  - Extraction of impacted wisdom teeth;
  - Services to treat an injury to sound natural teeth that are within 12 months of accident/injury;
  - TMJ surgery; and
  - Anesthesia for dental services only when the dental service itself is covered, is administered by an anesthesiologist and is done outside of the doctor's office.

Corrective surgery is covered if medically necessary for purposes of chewing and speaking.

The following services and supplies are covered only if needed because of accidental injury to sound and natural teeth that happened to you or your dependent while covered under this Plan. Treatment must be received within 12 months of the accident/injury.

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.
- **Oxford Health Plans** accepts the following oral surgeries as medical in nature and covered under the medical Plan as necessary:
  - Extraction of impacted wisdom teeth;
  - Services to treat an injury to sound natural teeth; and
  - TMJ surgery.

Organ/tissue transplants

Your Claims Administrator must be notified at least 17 business days (10 business days for Empire BlueCross BlueShield) before the scheduled date of any of the following (or as soon as reasonably possible):

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.

Donor charges for organ/tissue transplants

- In the case of an organ or tissue transplant, donor charges are considered covered expenses only if the recipient is a covered person under the Plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service unless the search is made in connection with a transplant procedure arranged by a designated transplant facility.

Qualified procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated transplant facility, the "medical care and treatment" and "transportation and lodging" provisions described in this section apply.

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Kidney transplants;

- Pancreas transplants;
- Kidney/pancreas transplants;
- Bone marrow/stem cell transplants;
- Cornea transplants are covered (Hawaii Plan); and
- Other transplant procedures when your Claims Administrator determines that they are medically necessary to perform the procedure as a designated transplant.

For **Aetna**, transplant services are covered as long as the transplant is not experimental or investigational and has been approved in advance. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluations and follow-up care. Each facility has been selected to perform only certain types of transplants, based on its quality of care and successful clinical outcomes. Under the Aetna ChoicePlan 500, a transplant will be covered as network care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered a non-participating facility for transplant-related services, even if the facility is considered a participating facility for other types of services.

Members must receive precertification for transplant procedures. When a member or physician calls Aetna to precertify a transplant evaluation, a case nurse will direct him or her to an Institutes of Excellence facility.

For **Empire BlueCross BlueShield**, there is tiered coverage based on the facility used for the transplant. If a Blue Distinction Center for Transplants (BDCT) is used, the transplant will be covered at 100% with access to the travel and lodging benefit. Blue Distinction Centers for Transplants meet stringent clinical criteria, established in collaboration with expert physician panels and national medical societies, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR) and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic reevaluation as criteria continue to evolve. You can contact the Empire customer service center at 1-866-290-9098 for additional coverage information as well as assistance in locating a BDCT facility.

Transplants performed at a participating transplant facility that is not a Blue Distinction Center for Transplants are covered at 90% with access to the travel and lodging benefit; all other facilities are covered at 70% with no access to the travel and lodging benefit. Travel and lodging is covered only if a participating BDCT facility is used.

Medical care and treatment

The covered expenses for services provided in connection with the transplant procedure include:

- Pretransplant evaluation for one of the procedures listed above;
- Organ acquisition and procurement;
- Hospital and physician fees;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant; and
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of $25,000 is payable for all charges made in connection with the search. (This maximum applies to the Oxford PPO plan. It does not apply to the Aetna and Empire BlueCross BlueShield plans.)
- Transportation and lodging

When available, the Plan will assist the patient and family with travel and lodging arrangements. Expenses for travel and lodging for the transplant recipient and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);

- Travel and lodging expenses are available only if the transplant recipient resides more than:
  - 100 miles from the designated transplant facility for **Aetna** plans;
  - **Empire BlueCross BlueShield** plans do not have a mileage requirement.
- If the patient is a covered dependent minor child, the transportation expenses of two companions (one companion for **Aetna plans**) will be covered; lodging expenses will be reimbursed at the $100 per-diem rate;
- A combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the Plan in connection with all transplant procedures. (For **Aetna plans**, a $10,000 maximum will apply to all non-health benefits in connection with any one type of procedure. These benefits are available until one year following the date of the procedure.)

If the covered person chooses not to receive his or her care in connection with a qualified procedure pursuant to this organ/tissue transplant section, the services and supplies received by the covered person in connection with that qualified procedure will be paid under the Plan if and to the extent covered by the Plan without regard to this organ/tissue transplant section.

- There may be some differences in coverage for transportation and lodging. **Empire BlueCross BlueShield** covers travel and lodging when a member uses a Blue Quality Center for Transplants.

Oxford Health Plans covers only those solid organ transplants that are non-experimental and non-investigational. All transplants must be performed by a UNOS (United Network for Sharing Organs) participating academic transplant center. All solid organ transplants must be performed in facilities that Oxford has specifically contracted and designated to perform these procedures to be eligible for Plan coverage.

The following types of solid organ transplants will be covered when performed by a UNOS participating academic transplant center:

- Heart transplant;
- Lung transplant;
- Heart-lung transplant;
- Liver transplant;
- Kidney transplant;
- Intestinal and multi-visceral transplants; and
- Pancreas transplant.

For more information, contact your Claims Administrator directly.

Orthoptic training

Training by a licensed optometrist or an orthoptic technician. The Plan covers a hidden ocular muscle condition where the eyes have a tendency to underconverge or overconverge. Manifest conditions of exotropia (turning out) or esotropia (turning in) are covered. Coverage is limited to 32 visits per calendar year.

Outpatient occupational therapy

See “Rehabilitation therapy” on page 87.

Outpatient physical therapy

See “Rehabilitation therapy” on page 87.

Prescribed drugs

Prescribed drugs and medicines for inpatient services.

Private-duty nursing care (combined with home health care)

Private-duty nursing care given on an outpatient basis by a licensed nurse (RN, LPN, or LVN). This service must be approved by your Claims Administrator.

- **Aetna ChoicePlan 500 and Empire BlueCross BlueShield ChoicePlan 500:** A combined network and out of network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered. Precertification is required. Additional visits may be covered if approved in advance by your Plan.
- **Oxford Health Plans:** Private-duty nursing is not combined with home health care. There is no maximum number of visits. One visit is equal to one

eight-hour shift. Inpatient private-duty nursing is not covered.

- **UnitedHealthcare Hawaii Plan:** At least 60 home heath visits are covered each year.

Psychologist services

Services of a psychologist for psychological testing and psychotherapy.

Rehabilitation therapy

Defined as short-term occupational therapy, physical therapy, speech therapy, and spinal manipulation:

- Services of a licensed occupational or physical therapist, provided the following conditions are met:
  - The therapy must be ordered and monitored by a licensed physician;
  - The therapy must be given according to a written treatment plan approved by a licensed physician. The therapist must submit progress reports at the intervals stated in the treatment plan; and
- Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to one of the following:
  - Surgery, radiation therapy, or other treatment that affects the vocal chords;
  - Cerebral thrombosis (cerebral vascular accident);
  - Brain damage due to accidental injury or organic brain lesion (aphasia);
  - Accidental injury that happens while the person is covered under the Plan;
  - Chronic conditions (such as cerebral palsy or multiple sclerosis); or
  - Developmental delay.

Inpatient

- Services of a hospital or rehabilitation facility for room, board, care, and treatment during a confinement. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available).
- Inpatient rehabilitative therapy is a covered service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently.

Outpatient

- Services of a hospital, comprehensive outpatient rehabilitative facility (CORF), or licensed therapist as described above.
- Coverage includes short-term cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure, or myocardial infarction.
- Coverage includes short-term pulmonary rehabilitation for the treatment of reversible pulmonary disease.
- All visit limits apply for both network and out of network, wherever the services are being provided, for example, at home, at a therapist's office, or in a free-standing therapy facility.
- **ChoicePlan 500:** Spinal manipulation therapy limited to 20 visits per calendar year. All other therapies combined are limited to 60 visits per calendar year.
- **Hawaii Health Plan**: Covers at least 30 days of each type of therapy each calendar year for restorative care with a separate chronic/developmental speech delay benefit of 24 visits per calendar year.

Skilled nursing facility services

- Room and board: Covered expenses for room and board are limited to the facility's regular daily charge for a semiprivate room.
- Other services and supplies.

Covered services are limited to the first 120 days of confinement each calendar year.

Speech therapy

See "Rehabilitation therapy" on page 87.

Spinal manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical

means or structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this Plan.

Surgery

Services for surgical procedures. (**Oxford Health Plans**: All surgical procedures must be precertified in advance.)

Reconstructive surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
  - Birth defect;
  - Sickness;
  - Surgery to treat a sickness or accidental injury; or
  - Accidental injury that happens while the person is covered under the Plan;
- Reconstructive breast surgery following a mastectomy including areolar reconstruction and the insertion of a breast implant. The Plan covers expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses, and the cost for treatment of physical complications at any stage of the mastectomy including lymphedemas. Normal Plan deductibles, coinsurance, and copayments will apply; and
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury that happens while the person is covered under the Plan.

Assistant surgeon services

Covered expenses for assistant surgeon services are limited to 20% of the amount of covered expenses for the primary surgeon's charge for the surgery for non-HMO/PPO Plans. An assistant surgeon generally must be a licensed physician. Physician's assistant services are not covered if billed on his or her own behalf. (**Aetna and Empire BlueCross BlueShield** cover assistant surgeon services for certain surgeries. **Aetna** covers registered nurses acting as assistant surgeons for certain surgeries. Contact Empire BlueCross BlueShield for information about which providers qualify as assistant surgeons.)

Multiple surgical procedure guidelines

If you are using an out-of-network provider for a surgical procedure, the following multiple surgical procedure guidelines will apply.

If more than one procedure will be performed during one operation — through the same incision or operative field — the Plan will pay according to the following guidelines:

- First procedure: The Plan will allow 100% of the negotiated or reasonable and customary fee.
- Second procedure: The Plan will allow 50% of the negotiated or reasonable and customary fee.
- Third and additional procedures: The Plan will allow 50% of the negotiated or reasonable and customary fee for each additional procedure.
- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or reasonable and customary fee for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or reasonable and customary fee for tertiary/additional procedures.

If billed separately, incidental surgeries will not be covered. An incidental surgery is a procedure performed at the same time as a primary procedure and requires few additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Termination of pregnancy

- Voluntary (i.e., abortion) and
- Involuntary (i.e., miscarriage).

Temporomandibular Joint Syndrome (TMJ)

Surgical treatment of TMJ does not include treatment performed by prosthesis placed directly on the teeth or physical therapy for TMJ.

Treatment centers

- Room and board and
- Other services and supplies.

Voluntary sterilization

- Vasectomy and
- Tubal ligation.

Reversals are not covered.

Well-child care

Office visit charges for routine well-child care exams and immunizations based on guidelines from the American Medical Association.

Wellness benefit

Covered expenses include:

- Routine physical exam (including a well-woman exam) is covered once per calendar year;
- Routine immunizations;
- Vision exam once every 24 months;
- Smoking cessation; and
- Weight control.

A $250 calendar year maximum applies to out of network services per covered family member. This maximum does not apply to wellness visits to network providers, for well-child care visits and immunizations, or for routine care under the Hawaii Health Plan.

Exclusions and limitations

There are services and expenses that are not covered under the Non-HMO/PPO Plans. The following list of exclusions and limitations applies to your Plan benefits unless otherwise provided under your HMO:

- Acupuncture and acupuncture therapy, except as listed in “Covered services and supplies” on page 78;
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan;
- Any services or supplies that are not medically necessary, as determined by the Claims Administrator;
- Beam neurologic testing;
- Biofeedback, except as specifically approved by the Claims Administrator;
- Blood, blood plasma, or other blood derivatives or substitutes, except as listed in “Covered services and supplies” on page 78;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Claims Administrator;
- Charges for canceled office visits or missed appointments; boutique, access, or concierge fees to doctors.
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments. **Hawaii Health Plan:** Treatment in a state facility, including care and treatment in a non-participating hospital owned or operated by any state government agency is covered;
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury;
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including, but not limited to, the type of care given by the facilities listed below:
  - Adult or child day care center;
  - Ambulatory surgical center;
  - Birth center;
  - Halfway house;
  - Hospice;
  - Skilled nursing facility;
  - Treatment center;

  - Vocational rehabilitation center; and
  - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, injured, or pregnant persons. If that type of facility is otherwise covered under the Plan, then benefits for that covered facility, which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital;
- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne. However, the Plan covers reconstructive surgery as outlined in "Covered services and supplies" on page 78;
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for Aetna Empire BlueCross BlueShield, or UnitedHealthcare);
- Coverage for an otherwise eligible person or a dependent who is on active military duty, including health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Custodial care made up of services and supplies that meets one of the following conditions:
  - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment;
  - Care that can safely and adequately be provided by persons who do not have the technical skills of a health care professional;
- Care that meets one of the above conditions is custodial care regardless of any of the following:
  - Who recommends, provides, or directs the care;
  - Where the care is provided; and
  - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself;
- Dental care or treatment to the mouth, teeth, gums, or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implant, See "Covered services and supplies" on page 78 for limited coverage of oral surgery and dental services;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs, such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation;
- Ecological or environmental medicine, diagnosis, and/or treatment;
- Educational services, special education, remedial education, or job training. The Plan does not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems and learning disabilities are not covered by the Plan; See "Covered services and supplies" on page 78 for limited coverage of cognitive services.
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home;
- Enteral feedings and other nutritional and electrolyte supplements, unless it is the sole source of sustenance;
- Expenses that are the legal responsibility of a third-party payer, such as Workers' Compensation or as a result of a claim;
- Expenses incurred by a dependent if the dependent is covered as an employee for the same services under the Plan;
- Experimental, investigational, or unproven services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or

pharmacological regimes, as determined by the Claims Administrator, unless approved by the Claims Administrator in advance. This exclusion will not apply to drugs:

  - That have been granted investigational new drug (IND) treatment or Group treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;
  - That the Claims Administrator has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. Refer to the "Glossary" for a definition of experimental, investigational or unproven services;
- Eyeglasses and contact lenses (Empire BlueCross BlueShield will cover eyeglasses or contact lenses within 12 months following cataract surgery);
- False teeth;
- Hair analysis;
- Hair transplants, hair weaving, or any drug used in connection with baldness. Wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation therapy. Wigs and hairpieces needed for endocrine, metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and preauthorized by the Claims Administrator;
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated;
- Herbal medicine, holistic, or homeopathic care, including drugs; (**Aetna**: not covered; however, discounts are available through the Aetna Natural Products and Services Discount Program; **Empire BlueCross BlueShield:** not covered; however, discounts on alternative medicine and treatment are available through the Empire SpecialOffers Program. Visit Empire's website at **www.empireblue.com/citi** for information about the Empire SpecialOffers Program); **Oxford**: not covered; however, discounts are available for some services under the Oxford Healthy Bonus Program;
- Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, are not covered. Improvements to your home or place of work, including, but not limited to, ramps, elevators, handrails, stair glides, and swimming pools, are not covered;
- Hypnotherapy, except when approved in advance by the Claims Administrator;
- Implantable drugs (other than contraceptive implants);
- Infertility services, except as described under "Covered services and supplies" on page 78. The Plan does not cover charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm or surrogate mothers or any charges associated with them.
- Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be preauthorized by the Claims Administrator
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs; (**Oxford** offers a $200 reimbursement every six months for employees who can prove they have had 50 gym visits in that time period and $100 every six months for spouses who can prove they have had 50 gym visits in that time period).
- Naturopathy;
- Nutritional counseling and nutritionists except as shown in "Covered services and supplies" on page 78;
- Occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a Workers' Compensation act or similar law. For persons for whom coverage under a Workers' Compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the Workers' Compensation act or similar law had that coverage been elected;
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips; Please contact the Plan for details. (These may not always be excluded.)
- Personal comfort or convenience items, including services and supplies that are not directly related to

medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services;

- Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered, when such services are:
  - For purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
  - Relating to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; or
  - To obtain or maintain a license of any type;
- Radial keratotomy or any other related procedures designed to surgically correct refractive errors, such as LASIK, PRK, or ALK;
- Recreational, educational, and sleep therapy, including any related diagnostic testing;
- Religious, marital, and sex counseling, including related services and treatment;
- Reversal of voluntary sterilizations, including related follow-up care;
- Routine hand and foot care services, including routine reduction of nails, calluses, and corns;
- Services not covered by the Plan;
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation;
- Services provided by your close relative (your spouse, child, brother, sister, or your or your spouse's parent or grandparent) for which, in the absence of coverage, no charge would be made; the **Hawaii Health Plan** excludes services provided by a parent, child, or spouse for which, in the absence of coverage, no charge would be made);
- Services given by volunteers or persons who do not normally charge for their services;
- Services required by a third party including, but not limited to, physical exams and diagnostic services in connection with:
  - Obtaining or continuing employment;
  - Obtaining or maintaining any license issued by a municipality, state, or federal government;
  - Securing insurance coverage;
  - Travel; and
  - School admissions or attendance, including exams required to participate in athletics unless the service is considered to be part of an appropriate schedule of wellness services;
- Services you are not legally obligated to pay for in the absence of this coverage;
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the Plan and is undergoing a covered transplant. Services for, or related to, transplants involving mechanical or animal organs are not covered;
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability;
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation;
- 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;
  - Urine autoinjections;
- Stand-by services: boutique, concierge, or on-call fees required by a physician;
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by the Claims Administrator;
- Telephone consultations;

- Therapy or rehabilitation including, but not limited to:
  - Primal therapy;
  - Chelation therapy (except to treat heavy metal poisoning);
  - Rolfing;
  - Psychodrama;
  - Megavitamin therapy;
  - Purging;
  - Bioenergetic therapy;
  - Vision perception training; and
  - Carbon dioxide therapy;
- Thermograms and thermography;
- Transsexual surgery, sex change, or transformation. The Plan does not cover any procedure, treatment, or related service designed to alter a participant's physical characteristics from his or her biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems;
- Treatment in a federal, state, or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws; this exclusion does not apply to the Hawaii Health Plan;
- Treatment of injuries sustained while committing a felony, assault, or during a riot or insurrection; this exclusion does not apply to the Hawaii Health Plan;
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you;
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Treatment of 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 for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column; and
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans, or any related products.

Additional medical Plan information

These features apply to ChoicePlan 500, the High Deductible Health Plan-Basic and Premier, the Hawaii Health Plan, and Oxford Health Plans PPO, as noted.

Infertility

The ChoicePlan, Hawaii Health Plan, and High Deductible Health Plan-Basic and Premier cover the medical and prescription drug expenses associated with infertility treatment such as in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments. Infertility treatment is also covered for any condition or treatment of a condition that would destroy the function of the ovaries or testes.

If both you and your spouse (whether same or opposite sex)/civil union partner/domestic partner are enrolled in Citi coverage, both of you together are eligible for the lifetime maximum benefits under the infertility provision (medical and prescription drug as listed in the bullets below). *Each of you is not eligible for a separate lifetime maximum benefit.*

The infertility benefit covers:

- Prescription drug expenses (managed by Express Scripts) associated with infertility treatment up to a $7,500 lifetime infertility prescription drug maximum for participants and
- Medical expenses up to a $24,000 lifetime infertility medical maximum across ChoicePlan 500 and High

Deductible Health Plan-Basic and Premier in and out of network combined and the Hawaii Health Plan.

For the donor, the Plan covers the cost of physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs. The Plan does not cover surrogates or surrogate charges.

The lifetime maximum per family can be spent in one year or over a number of years. If you change medical options, the Claims Administrators will keep track of the amount you have remaining toward this benefit. *Expenses for your donor are counted toward your lifetime family maximum.*

Call your Plan if you have questions about specific procedures or treatments.

For Oxford Health Plans PPO and HMO participants: Your Plan may offer different infertility coverage, if any. Contact your Plan for details.

Mental health and substance abuse benefits

Effective January 1, 2010, all visits for both inpatient and outpatient mental health and substance abuse treatment will be reimbursed at the same coinsurance level as other medical services, according to your Plan, subject to medical necessity.

The plans administered by Aetna, Empire BlueCross BlueShield, and Oxford Health Plans provide confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

When you call your Plan at the toll-free number on your medical plan ID card, you will speak with an intake coordinator who will help find the right network care provider. In an emergency, the intake coordinator also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility.

You must call your Plan before seeking treatment for mental health or chemical dependency treatment. Call your Plan for the names of network providers.

Programs available to Aetna participants

Aetna offers the National Medical Excellence Program® (NME), which can arrange for care when appropriate care is not available in your local service area. Specifically, NME may coordinate the care for participants who need:

- Bone marrow or organ transplantation;
- "Investigational" or new technology (when standard care is not available);
- Preauthorized care that is not available within 100 miles of a participant's home; or
- Emergency care while temporarily traveling outside the United States.

In addition, the program will cover the cost of transportation and lodging for you and a companion if the facility to which you are directed is more than 100 miles from your home. The lodging expense maximum is $50 per night, and the travel and lodging maximum is $10,000. For details, contact the Member Services number on your medical Plan ID card.

National Advantage Program (NAP)

Available to Aetna participants using out-of-network services.

By using NAP, you have access to discounted rates for many hospital and doctor's claims that would otherwise be paid as billed or for emergency/medically necessary services that are not provided in the Aetna network. For more information, call Aetna at 1-800-545-5862.

Aetna tools

Aetna offers the following tools to help you manage your health care expenses. For a preview of these tools, visit the Aetna website for participants, Aetna Navigator, at **www.aetna.com**. If you are not a participant, you can tour the Aetna website at **www.aetna.com/members/tour/index.html**.

- **Aetna Navigator Hospital Comparison Tool:** Provides a report that compares hospitals in your area for more than 160 diagnoses and procedures. This information can help you decide where to obtain care.
- **Estimate the cost of care:** Allows you to compare the estimated average costs for 200 different health care services in your area. You can see the potential

for savings by choosing a doctor who participates in the Aetna network.

- **Cost and quality transparency:** This tool is designed to help you make informed health care decisions based on the actual costs of care and the clinical quality of physicians in select areas.

  In the cost-only markets, doctor-specific charges for health care services are displayed. These markets are Anchorage and Fairbanks, AK; Eastern Washington; El Paso, TX; New Jersey; West Virginia; Charlotte, NC; Detroit and East Midland, MI; Las Vegas, NV; Massachusetts; Milwaukee, WI; and Utah.

  In the cost and quality transparency markets, information is taken from Aetna's Aexcel evaluation process, which is used to evaluate a specific panel of specialists based on defined measures of clinical performance and cost-efficiency. These markets are Arizona; Atlanta, GA; Cincinnati, Cleveland, and Columbus, OH; Central Valley, Los Angeles, San Diego, and Northern, CA; Colorado; Delaware; Connecticut; Metropolitan Washington, DC; Jacksonville, Tampa, Orlando, and South FL; Austin, Dallas, Houston, and San Antonio, TX; Maine; Metro New York; Seattle, WA; Chicago, IL; Indianapolis, IN; Pittsburgh, PA; Kansas City, MO and KS; Richmond, VA; and Oklahoma City and Tulsa, OK.

Programs available to Empire BlueCross BlueShield participants

Blue Distinction Centers for Specialty Care℠ are facilities recognized for their distinguished clinical care and processes in the areas of transplant surgery, bariatric surgery, cardiac care, and complex and rare cancers.

To identify a Blue Distinction facility, visit **www.empireblue.com/citi**. Click on "Find a Doctor," "Across the Country," and, in the upper right, "Blue Distinction Centers for Specialty Care."

Blue Distinction Centers for Transplants

The Blue Distinction Centers for Transplants (BDCT) is a center of excellence of bone marrow and organ transplant program offered through participating Blue Cross Blue Shield Plans. All institutions selected as BDCT centers of excellence must meet stringent criteria. BDCT provides a range of services for the following types of transplants:

- Heart;
- Lung;
- Liver;
- Simultaneous pancreas kidney (SPK); and
- Bone marrow/stem cell.

In addition, travel and lodging benefits are available to participants approved for transplant services. Benefits include the cost of airline, bus, rail, or taxi fare necessary for the patient and one companion (two companions if the patient is under age 19). A $50-per-day maximum for one person and $100-per-day maximum for two people for charges related to lodging and a $10,000 lifetime maximum for all travel and lodging services combined applies.

For specific coverage and additional information about these benefits, call Member Services at the telephone number on your medical Plan ID card.

Blue Distinction Centers for bariatric surgery, cardiac care, and complex and rare cancers

The national Blue Distinction Centers offers specialty care in bariatric surgery, cardiac care, and complex and rare cancer. These specialty center networks help members identify facilities that have met high efficiency and quality standards.

Online member tools

Make more informed choices about the medical care you and your family receive — and better understand your options — with Empire BlueCross BlueShield's decision-support tools at **www.empireblue.com/citi**.

- **Care Comparison:** An innovative collection of online decision-support tools to help you make more informed choices about the medical care that you and your family receive. You will find the data you need to evaluate hospitals based on clinical quality measures and other key quality indicators, such as hospital reputation and characteristics (within a given radius of the area you choose); estimate the costs of specific health care services and procedures; and more.

- **Surgical Procedures:** If you are thinking about surgery, you should have as much information as possible. The Surgical Procedures tool gives fast and easy access to reliable medical information along with graphic animation that demonstrates different types of surgery. It can help you protect your most valuable asset: your health.

Programs available to Oxford Health Plans PPO participants

Cancer Resource Services

To use Cancer Resource Services, you must enroll before receiving any treatment. If you are receiving treatment at the time you are hired or newly eligible for benefits, call Cancer Resource Services immediately to enroll. Call Cancer Resource Services at 1-866-936-6002 from 8 a.m. to 8 p.m. ET on weekdays, excluding holidays.

Cancer Resource Services can assist when you or a covered dependent is diagnosed with cancer and must make difficult and important decisions such as what kind of treatment to get and where to get treatment.

In addition to helping you answer these questions, Cancer Resource Services also can arrange for and coordinate access to a full range of comprehensive cancer treatment services through "centers of excellence." Centers of excellence cancer centers provide:

- Comprehensive, highly specialized teams of experts with extensive experience in cancer diagnosis and treatment, including rare cancers;
- Second-opinion services if you are unsure about your diagnosis or what treatment is right for you;
- Experience in performing a large number of cancer surgeries and other complex procedures; and
- Access to new experimental treatments that may be an option for some patients.

To learn more about Cancer Resource Services or to enroll, call 1-866-936-6002 or visit the Cancer Resource Services website at **www.urncrs.com**. You are not charged for this service, and you have no obligation to use a Cancer Resource Services center.

Claims and appeals

Claims and appeals for UnitedHealthcare medical plans

The amount of time UnitedHealthcare will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for preservice claims and 30 days for post-service claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;

- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

The Customer Service telephone number is on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

UnitedHealthcare level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the ID number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of preservice claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

UnitedHealthcare level two appeal

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

For appeals of preservice claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

UnitedHealthcare urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for Aetna medical plans

The amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

You may obtain a medical benefits appeals claim form by calling the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

The form explains how and when to file a claim.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

Appeals for Aetna medical plans

You will have two levels of appeal for both administrative and clinical appeals in accordance with the definitions below.

Administrative appeals are defined as appeals in response to denials based on contractual or benefit exclusion, limitation, or exhaustion not requiring clinical judgment. Administrative denials do not require a clinician to interpret the contractual limitation or apply clinical judgment to the limitation.

Clinical appeals are defined as appeals in response to denials based on clinical judgment for the determination and application the terms of the Plan to the member's medical circumstances.

You will have 180 days following receipt of a claim denial to appeal the decision. You will be notified of the decision no later than 15 days (for preservice claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your ID card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claims Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received. If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first level appeal and a notice will be sent to you explaining the decision.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You must exhaust the applicable level one and level two processes of the appeal procedure before you contact the Department of Insurance to request an investigation of a complaint or appeal; file a complaint of appeal with the Department of Insurance; or establish any litigation, arbitration or administrative proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure.

External Review

An "External Review" is a review by an independent physician, with appropriate expertise in the area at issue, of claim denials based on lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided the following are satisfied:

- You have exhausted the Aetna appeal process for denied claims, as outlined in this "Claims and appeals for Aetna medical plans" section and you have received a final denial;
- The appeal is made by the member or the member's authorized representative.

- The final denial was based on a lack of medical necessity or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue for which the member is financially responsible exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the External Review Organization that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form and must follow the applicable Plan's contractual documents and Plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna or the Plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request for Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna.

For an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

Your may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Claims and appeals for Empire BlueCross BlueShield medical plans

Timing of initial claim approval or denial

The time within which your claim will be approved or denied will depend on the type of claim you file.

- **For claims involving urgent care**, you will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Empire BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life health or the ability to regain maximum function or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.
- **For medical care requiring precertification approval (called a "precertification claim")**, you will be notified of the approval or denial of your claim

no later than 15 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 15-calendar day period to 30 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to reach a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.

- **For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions")**, you will be notified in advance of any decision by Empire BlueCross BlueShield to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you wish to extend the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your claim is received, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end.
- **For all other care (e.g., reimbursement for medical services already received)**, you will be notified of the approval or denial of your claim no later than 30 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 30-calendar day period to 45 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.
- **Contents of claim denial notice:** If you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:
  - The specific reasons for the denial;
  - Reference to the specific Plan provisions on which the denial is based;
  - A description of any additional material or information Empire BlueCross BlueShield requires and an explanation of why it is necessary;
  - A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA but only after you have followed the Plan's claims procedures;
  - If an internal rule, guideline, or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline, or protocol or a statement that it will be provided on request, free of charge; and
  - If the denial is based on a medical necessity exclusion, experimental treatment exclusion, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Appeal filing deadlines

Action	Expedited appeal	Prospective standard appeal	Retrospective appeal
You may appeal to Empire BlueCross BlueShield in writing (for an urgent care claim, orally or in writing)	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified
Empire BlueCross BlueShield will notify you about the appeal decision	Within 72 hours after appeal is received	Within 15 calendar days after the appeal is received	Within 30 calendar days after the appeal is received
You can make a second appeal to Empire BlueCross BlueShield in writing	N/A	Within 60 calendar days after the appeal denial is received	Within 60 calendar days after the appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 calendar days after the appeal is received	Within 30 calendar days after the appeal is received

First appeal to Empire BlueCross BlueShield: You have 180 calendar days after receipt of the denial to file an appeal with Empire BlueCross BlueShield. Your appeal must be in writing, except that an appeal of an

urgent care claim may be made orally or in writing. Be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim.

Approval or denial of appeal: Empire BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims; 15 calendar days for precertification claims; and 30 calendar days for all other claims.

If your claim is based on a medical judgment, in reviewing your appeal, Empire BlueCross BlueShield will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the health care professional, upon request.

If Empire BlueCross BlueShield denies your appeal, the denial notice will include:

- The specific reasons for the denial;
- Reference to the specific Plan provisions on which the denial is based;
- A statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your first appeal (in the case of an urgent care claim) or on your second appeal (in the case of all other claims);
- If an internal rule, guideline, or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline, or protocol or a statement that it will be provided on request, free of charge; and
- If the denial is based on a medical necessity exclusion, experimental treatment exclusion, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Second appeal to Empire BlueCross BlueShield: For claims other than urgent care claims, if Empire BlueCross BlueShield denies your appeal, you have 60 calendar days from receiving the appeal denial to send a second appeal to Empire BlueCross BlueShield. Your appeal must be in writing. Empire BlueCross BlueShield will send you its written decision within 15 calendar days for precertification claims and 30 calendar days for all other claims.

If you are appealing an urgent care claim, Empire BlueCross BlueShield's decision on your first appeal will be final.

Authorized representative: If you appeal an adverse decision to Empire BlueCross BlueShield or the Medical Review Board, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Empire BlueCross BlueShield referred to in its review.

Legal action: You must follow these claims procedures completely, which require one appeal to Empire BlueCross BlueShield for urgent care claims and two appeals to Empire BlueCross BlueShield for all other claims, before you can take legal action. After you receive the final decision from Empire BlueCross BlueShield, you can take legal action.

Claims and appeals for Oxford Health Plans medical plans

The amount of time Oxford Health Plans will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring notification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*

Type of claim	Timeline after claim is filed
Urgent care claims (for services requiring notification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for preservice claims and 30 days for post-service claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the Plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the address of the Claims Administrator.

The Customer Service telephone number is on your ID card. Customer Service representatives are available to take your call during regular business hours Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

Oxford Health Plans level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the ID number from the ID card;
- The date(s) of medical service(s);
- The provider's name;
- The reason you believe the claim should be paid; and
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of preservice claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

Oxford Health Plans level two appeal

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first level appeal decision.

For appeals of preservice claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding. Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Oxford Health Plans urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claims Administrator's decisions are conclusive and binding.