Prescription drugs

Express Scripts manages the Citigroup Prescription Drug Program for participants in ChoicePlan 500, the High Deductible Health Plans - Basic and Premier, and the Hawaii Health Plan.

Prescription drug benefits for the Oxford Health Plans PPO are provided through Medco. For information on the Oxford PPO prescription drug benefits, see "Prescription drugs in the Oxford PPO" on page 129.

Prescription drug benefits for HMOs are provided through the HMOs, and are not included here. Contact your HMO for its prescription drug benefits.

Express Scripts covers FDA (Food and Drug Administration)-approved (federal legend) medications that require a prescription from your doctor. The Plan does *not* cover over-the-counter (OTC) products such as aspirin, vitamins, supplements, or other products that do not require a prescription.

Medications for which there are OTC products of the same chemical equivalents are not covered under this program. These decisions are made at the discretion of Express Scripts. The majority of these OTC products are for seasonal allergies or for coughs and cold. None of the drugs are maintenance medications intended for long-term use. If you have any questions about whether a medication is covered, call Express Scripts at **1-800-227-8338**.

Express Scripts offers two ways to purchase prescription drugs:

1. Through a network of retail pharmacies nation wide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection
2. Through the Express Scripts Home Delivery program where you may save money by having your maintenance and preventive drugs delivered by mail.

You will pay a deductible, as shown in the following table, for drugs purchased at a retail pharmacy, before the Plan will pay benefits. *You will never pay more than the cost of the drug.*

Contents

Express Scripts Prescription drug benefits at a glance

PRESCRIPTION DRUG PROGRAM AT A GLANCE			
	ChoicePlan 500	High Deductible Health Plan – Basic and Premier*	Hawaii Health Plan
Deductible Applies to drugs purchased at a retail pharmacy	$100 per person/$200 family maximum (prescription drug deductible)	**Basic:** Individual: $2,100 network/$3,100 out of network; Family: $4,200 network/$6,200 out of network **Premier:** Individual: $1,200 network/$2,400 out of network; Family: $2,400 network/$4,800 out of network	$50 per person/$100 family maximum
Copayment for up to a 34-day supply at a network pharmacy after you meet your deductible			
• Generic drug**	$5		$10
• Preferred brand name or formulary drug***	$30		$20
• Non-preferred brand name or non-formulary drug • You may have the same prescription filled up to three times at a retail pharmacy. On the fourth fill, you will pay 100% of the cost of the medication****	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after you meet the deductible		50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after a $50/$100 deductible
Copayment for a 90-day supply through the Express Scripts Home Delivery program (no deductible to meet)			
• Generic drug**	$12.50		$25
• Preferred brand name or formulary drug***	$75		$50
• Non-preferred brand name or non-formulary drug	50% of the cost of the drug with a minimum payment of $125 to a maximum of $375		50% of the cost of the drug with a minimum payment of $100 to a maximum of $250
Copayment for a 30-day supply of specialty medication through the CuraScript Specialty Pharmacy or at a retail network pharmacy			
• Generic drug**	$5 (no deductible to meet if purchased through CuraScript)	$5 copay per prescription after deductible	$10
• Preferred brand name or formulary drug***	$60 (no deductible to meet if purchased through CuraScript)	$60 copay per prescription after deductible	$20
• Non-preferred brand name or non-formulary drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 (no deductible to meet if purchased through CuraScript)	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 after deductible	50% of the cost of the drug with a minimum payment of $40 to a maximum of $100 after a $50/$100 deductible
Benefits at an out-of-network pharmacy	50% of your cost after you meet the deductible; you must file a claim for reimbursement		

* In the High Deductible Health Plan, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits except for certain preventive drugs. For a list of these preventive drugs, call Express Scripts at **1-800-227-8338** or visit **www.express-scripts.com**. Your cost for these preventive drugs is the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

** The use of generic equivalents whenever possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional about this distinction. If you request a brand name drug and a generic alternative is available, you will pay the difference between the cost of the brand-name drug and the generic drug in addition to the copayment for the generic drug.

***Citi does not determine formulary drugs. Rather, Express Scripts brings together an independent group of practicing doctors and pharmacists who meet quarterly to review the formulary list and make determinations based on current clinical information. Call Express Scripts at **1-800-227-8338** for a copy of its Preferred Formulary or visit **www.express-scripts.com**.

**** Retail pharmacy purchases are not reimbursable under the Plan after three refills of the same drug.

NOTE: Pharmacy and/or home delivery copayments do not count toward your medical plan's annual deductible or out-of-pocket maximum. At out-of-network pharmacies:

- For non-emergencies: You will be reimbursed for 50% of the covered drug cost after the applicable deductible when a claim is filed.
- For emergencies: Reimbursement for all but the network copayment may be available. Please call Express Scripts at **1-800-227-8338**.

Retail network pharmacies with Express Scripts

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the thousands of pharmacies nationwide that participate in the Express Scripts network and obtain up to a 34-day supply for your copayment (once you meet your deductible).

For some drugs to be covered, you may have to provide a letter from your physician. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

If you expect to have the prescription filled more than three times, use the Express Scripts Home Delivery program.

To find out whether a pharmacy participates in the Express Scripts network:

- Ask your pharmacist;
- Visit **www.express-scripts.com** and use the online pharmacy locator; or
- Call Express Scripts at **1-800-227-8338** and follow the prompts for the retail pharmacy locator.

A network pharmacy will accept your prescription and prescription drug ID card, and, once you have met your deductible, charge the appropriate copayment/ coinsurance for a covered drug. Your copayment/ coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the Express Scripts Preferred Formulary, or a non-preferred brand-name drug.

'Dispense as written'

If your physician writes "Dispense as written" on the prescription or if your physician prescribes a drug for which there is no generic equivalent, your copayment is that of either a preferred brand-name drug or a non-preferred brand-name drug. If the pharmacy's price is less than the copayment, you will pay the pharmacy's price. Benefits do not start until the annual deductible has been met.

Send all completed claim forms to:

Express Scripts Pharmacy
P.O. Box 66566
St. Louis, MO 63166

Using your prescription drug ID card

You must use your prescription drug ID card when purchasing drugs at a retail pharmacy.

You will have a 45-day grace period from the effective date of your enrollment in which you will be covered even though you do not present your prescription drug ID card when purchasing drugs at a retail pharmacy. If you do not present your prescription drug ID card at the time of service during this initial 45-day period, you will still be reimbursed for 100% of the cost of any covered drugs, less the network copayment, after meeting the annual deductible.

If you do not use your card at network pharmacies *after* your first 45 days of participation, you will be reimbursed for only 50% of the cost of the prescription drug after you have met the annual deductible.

In either case, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed.

Meeting your deductible

When you buy a prescription drug at a retail pharmacy, you must meet the applicable deductible (individual or family) before the Plan will pay benefits.

For answers to your questions about the applicable deductibles, call Express Scripts at **1-800-227-8338**.

Express Scripts Home Delivery

For prescriptions for maintenance medications that you have filled more than three times, you must use the Express Scripts Home Delivery program to avoid paying 100% of the cost of the drug.

Through Express Scripts Home Delivery you can buy up to a 90-day supply at one time. You will make one copayment for each prescription drug or refill, and your cost will be less than what you would pay to purchase the same amount at a retail network pharmacy.

Prescription drugs

When you use Express Scripts Home Delivery:

- Your medications are dispensed by one of Express Scripts Home Delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no cost to you. You will pay for express shipping.
- You can order and track your refills online at **www.express-scripts.com**, or you can call Express Scripts at **1-800-227-8338** to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

Obtaining a refill of a maintenance medication with Express Scripts

The first three times you purchase a maintenance medication at a retail network pharmacy or out-of-network pharmacy after you meet the applicable deductible, you will pay the applicable copayment or coinsurance. You will receive a notice from Express Scripts advising you of the benefits of the Express Scripts Home Delivery program.

If, after the prescription is filled three times, you still want to purchase this maintenance medication at a retail pharmacy instead of through Express Scripts Home Delivery, you will pay 100% of the cost of the current prescription or a new prescription for the same medication and strength. Maintenance drugs, generally, are drugs taken on a regular basis for conditions such as asthma, heartburn, blood pressure, and high cholesterol. If you need to know if your prescription drug is considered a maintenance medication, call Express Scripts at **1-800-227-8338**.

Specialty medication with Express Scripts

CuraScript — Express Scripts' specialty pharmacy — dispenses oral and injectable specialty medications for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer, and rheumatoid arthritis. Prescriptions sent to Express Scripts Home Delivery that should be filled by CuraScript will be forwarded. Specialty medications purchased at a retail pharmacy or through CuraScript are limited to a 30-day supply.

CuraScript offers the following:

- Once you are using the CuraScript program, CuraScript will call your doctor to obtain a prescription and then call you to schedule delivery.
- Prescription drugs can be delivered via overnight delivery to your home, work, or doctor's office within 48 hours of ordering.
- You are not charged for needles, syringes, bandages, sharps containers, or any supplies needed for your injection program.
- A CuraScript team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- CuraScript will send monthly refill reminders to you.

To learn more about CuraScript's services, including the cost of your prescription drugs, call CuraScript at **1-866-413-4135**.

Controlled substances with Express Scripts

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state limits.

Because special requirements for shipping controlled substances may apply, Express Scripts uses only certain Home Delivery pharmacies to dispense these medications. If you submit a prescription for a controlled substance along with other prescriptions, it may need to be filled through a different pharmacy from your other prescriptions. As a result, you may receive your order in more than one package.

For more information about controlled substances and for the laws in your state, call Express Scripts at **1-800-227-8338**.

Note: Kentucky and Hawaii state laws require you to provide your Social Security number or government ID to the pharmacy or to Express Scripts before it can dispense your medication(s).

Generics Preferred with Express Scripts

The Generics Preferred program was designed to encourage the use of generic drugs instead of brand-name drugs. Typically, brand-name medications are 50% to 75% more expensive than generics.

If you choose the brand-name drug, where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.*

Prior authorization with Express Scripts

To purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive "prior authorization" from Express Scripts before these drugs will be covered under the Citigroup Prescription Drug Program.

- Examples of medications requiring "prior authorization" are Retin-A cream, growth hormones, anti-obesity medications, rheumatoid arthritis medications, and Botox.
- Examples of medications whose quantity will be limited are smoking cessation products, migraine medications, and erectile dysfunction medications.

Other medications, such as certain non-steroidal anti-inflammatories, will be covered only in situations where a lower-cost alternative medication is not appropriate.

To determine if your medication requires a prior authorization or is subject to a quantity limit, call Express Scripts at **1-800-227-8338** or visit the Express Scripts website at **www.express-scripts.com**. Your pharmacist can also determine if a prior authorization is required or a quantity limit will be exceeded at the time your prescription is dispensed.

If a review is required, you or your pharmacist can ask your doctor to initiate a review by calling **1-800-224-5498**. After your doctor provides the required information, Express Scripts will review your case, which typically takes one to two business days. Once the review is completed, Express Scripts will notify you and your doctor of its decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you can purchase the drug at full cost.

Note: If you are covered under the Oxford Plan, you can obtain the appropriate telephone number from Oxford by calling the telephone number on the back of your ID card.

Medical necessity review (for non-formulary drugs) with Express Scripts

Under certain circumstances, you and your doctor may request that Express Scripts perform a medical review of your medications. For additional information and instructions on how your doctor can request a review, call Express Scripts at **1-800-227-8338**.

High Deductible Health Plan information

The High Deductible Health Plan covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

For a list of these preventive medications, call Express Scripts at **1-800-227-8338**. You can also visit **www.express-scripts.com**. From the Benefit Overview menu, select "Coverage & Copayments."

If, for 2011, you are enrolled in an HMO or are not enrolled in Citi coverage *and* you are considering enrolling in the High Deductible Health Plan for 2012, visit **https://member.express-scripts.com/preview/citigroup2012** to view the 2012 list of preventive medications. On the home page scroll to "High Deductible Health Plan Preventive Drug List" for a link to the list.

For all other covered drugs, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits.

Covered drugs

The following drugs and products are covered under the Citigroup Prescription Drug Program:

- Federal legend drugs;

Prescription drugs

- State-restricted drugs;
- Compounded medications of which at least one ingredient is a legend drug;
- Insulin;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except blood glucose testing monitors);
- Oral and injectable contraceptives (up to a 90-day supply);
- Fertility agents;
- Legend vitamins;
- Amphetamines, through age 18;
- Drugs to treat impotency, for males age 18 and older (quantity limits apply);
- Retin-A/Avita (cream only), through age 34;
- Retin-A (gel), with no age restrictions; and
- Botulinum Tox Type A or B (Botox/Myobloc).

Some drugs require prior authorization. They include:

- Legend anti-obesity preparations;
- Amphetamines, age 19 and over;
- Retin-A/Avita (cream only), age 35 and over;
- Botulinum Tox Type A or B (Botox/Myobloc); and
- Zelnorm.

Step Therapy

Some brand-name medications, such as, but not limited to, certain non-steroidal anti-inflammatories and COX2 may require Step Therapy and will be covered only in situations where a lower-cost alternative medication is not appropriate after a trial with that lower-cost alternative. To determine if your prescription requires Step Therapy, or is subject to limitations, call Express Scripts at **1-800-227-8338**. If you have a discontinuance or lapse in therapy of more than 120 days while using the brand-name medication and need to restart therapy, you will be subject to another review under the Step Therapy program to determine if the cost of the brand-name medication will be covered under the Plan.

Other limits

Coverage limits apply to some categories of drugs. These categories include:

- Erectile dysfunction;
- Anti-influenza (retail only);
- Smoking deterrents;
- Migraine medications;
- H2-receptor antagonists; and
- Proton pump inhibitors

Drugs not covered

The following drugs and products are not covered under the Citigroup Prescription Drug Program. This list is not exhaustive and there may be other drugs that are not covered:

- Non-federal legend drugs;
- For the ESI coverage, but not for Oxford, prescription drugs for which there are OTC equivalents available, including, but not limited to, Benzoyl Peroxide, Hydrocortisone, Meclizine, Ranitidine, and Zantac;
- Contraceptive jellies, creams, foams, devices, or implants;
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Relenza (this exclusion applies only to Express Scripts Home Delivery; prescriptions for Relenza are covered if filled at a retail pharmacy);
- Tamiflu;
- Gardisil and Zostavax (vaccinations are covered under the medical plan; therefore, the provider must bill under medical plan)
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices and appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or is for cosmetic purposes only (e.g., Renova®);
- Allergy sera;

- Biologicals, blood or blood plasma products;
- Drugs labeled "caution — limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended-care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates, or allows to be operated, a facility for dispensing pharmacetuicals on its premises;
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order; and
- Charges for the administration or injection of any drug.

Claims and appeals for Express Scripts

The amount of time Express Scripts 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 due to matters beyond the control of the Claims Administrator (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

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

Claim forms may be obtained at **www.express-scripts.com**. These forms tell you 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.

Express Scripts 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. 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.

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 the 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 the appeal of a denied claim. 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 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 the appeal of a denied claim. 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.

Express Scripts 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 as the Plan Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of 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 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.

Express Scripts 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 Plan. The Claims Administrator's decisions are conclusive and binding.

Notwithstanding the foregoing, the Health Care Reform Law enacted in 2010 requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option. Citi is working in good faith to implement each of the new standards in a timely manner and will provide additional communications to participants regarding the new standards after final guidance has been issued. A new external appeal option may be available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The rules governing how the external review process will work are not yet fully established. If your claim for benefits has been denied and you received an adverse benefit determination in response to your subsequent appeal, call the Citi Benefits Center through ConnectOne at **1-800-881-3938** for information on how to request an external review. From the ConnectOne main menu, choose the "health and welfare" option.

Prescription drugs in the Oxford PPO

Feature	Retail	Mail order
When to use	When you need a prescription drug on a short-term basis, for example, an antibiotic to treat an infection	For prescription drugs you use on a regular basis, for example, maintenance drugs to treat asthma or diabetes
Quantity available for each prescription or refill	Up to a 34-day supply	Up to a 90-day supply with refills for up to one year
Your copayment for each prescription or refill	At network pharmacies:	
	• $10 for a generic drug	• $20 for a generic drug
	• $20 for a preferred brand-name drug	• $40 for a preferred brand-name drug
	• $40 for a non-preferred brand-name drug	• $80 for a non-preferred brand-name drug
	At out-of-network pharmacies:	
	For non-emergencies: You will be reimbursed for 50% of the covered drug cost after the applicable deductible when a claim is filed.	
	For emergencies: Reimbursement for all but the network copayment may be available. Call the Plan for details.	

Retail network pharmacies with Oxford

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the pharmacies that participate in the Oxford network and obtain up to a 34-day supply for your copayment.

If your prescription is for medication that you expect to use on an ongoing basis (like a maintenance medication used to treat a chronic condition such as high cholesterol), use the Medco By Mail mail-order pharmacy benefit.

To find out whether a pharmacy participates in the Oxford network:

- Ask your pharmacist;
- Visit **www.oxhp.com**; or
- Call Oxford at **1-800-396-1909**

A network pharmacy will accept your prescription and prescription drug ID card charge the appropriate copayment/ coinsurance for a covered drug.

Medco by mail

Oxford's mail-order pharmacy benefits are administered through Medco Health Solutions. Medco By Mail, Medco's Health Home Delivery Pharmacy Service, offers you the ability to obtain up to a 90-day supply of certain medications.

Filling a prescription for the first time

You can submit a prescription to Medco By Mail in one of three ways:

- **By mail**: Send the prescription, along with the appropriate copayment and the Medco Health Home Delivery Service Order Form, to Medco Health at:

  Medco by Mail Medco Health Solutions of Fairfield
  P.O. Box 747000
  Cincinnati, OH 45274-7000

- **By Fax**: Your doctor can fax the prescription directly to Medco.
- **Online**: Visit **www.medcohealth.com.** Click on "Order Center", then "Request a new prescription from your doctor" and follow the on-screen instructions.

Prescription drugs

Refilling a prescription

You can easily refill a prescription online, by phone, or by mail.

- **By mail**: Use the refill order form that comes with your prescription to order a refill. Send the form, along with your copayment, using the return envelope provided.
- **By phone**: Call Medco's automated refill system at **1-800-905-0201**.
- **Online**: Log on to **www.medcohealth.com** and go to "Order Center". Choose from your available prescription refills and follow the on-screen instructions to check out.

To be sure you don't run out of medication, you should order your refill 14 days before your medication runs out.

Covered drugs

For a list of drugs that are covered under the Oxford PPO prescription drug benefit, as well as information about drugs that are excluded from coverage, visit **www.oxhp.com**.

Claims and appeals for Oxford

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*
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

* The 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 telephone, you may submit your question in writing. However, if you are not met 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 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 consideration of 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 met 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 the 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. **Note:** 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.

Notwithstanding the foregoing, the Health Care Reform Law enacted in 2010 requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option. Citi is working in good faith to implement each of the new standards in a timely manner and will provide additional communications to participants regarding the new standards after final guidance has been issued. A new external appeal option may be available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. The rules governing how the external review process will work are not yet fully established. If your claim for benefits has been denied and you received an adverse benefit determination in response to your subsequent appeal, please contact the Citi Benefits Center at **1-800-881-3938** for information on how to request an external review.