About Your Health Care Benefits

Amended and Restated as of January 1, 2009

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This document is a component of the plan documents for the Citi Health Benefit Plan, the Citi Dental Benefit Plan, the Citi Vision Benefit Plan, the Citi Employee Assistance Program and the Health Care Spending Account (hereinafter referred to as the "Plans") for eligible employees of Citi and its participating employers (hereinafter referred to as "Citi", unless otherwise specified). **Citi reserves the right to change or discontinue any or all of the benefits coverage or programs described here at any time, with or without notice.**

The benefits and programs described in this document are in effect as of January 1, 2009. The terms and conditions of these Plans may also be further prescribed in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

This document is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws and regulations. In addition, this document is designed to comply with the requirements of a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"). It does not create a contract or guarantee of employment between Citi and any individual. Your employment is always on an at-will basis. In addition, benefits provided under the Plans described in this document are not in any way subject to your or your dependent's debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

As you read the document you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document, or in the Plans.

This document provides no guarantee that you are eligible to participate in every benefit or program described. Each Plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citi in no way guarantees the payment of any benefit which may be or becomes due to any person under the Plans.

If you have any questions about this document or certain provisions of your benefit plans, or would like to receive copies of an insurance policy or other document forming a part of any Plan described in this document, please call the Benefits Service Center at ConnectOne at 1-800-881-3938 and select the Health Benefits options.

About Your Health Care Coverage

Eligibility

Citi provides benefits coverage for you, your **spouse, civil union partner** or **qualified domestic partner**, and/or **eligible dependents**.

For employees

You are only eligible to participate in the Plans (as defined above) if you work for a "participating employer" in the United States for a regular semimonthly or monthly paycheck as either an active full-time employee regularly scheduled to work 40 hours or more a week or an active part-time employee regularly scheduled to work 20 hours or more a week.

A "participating employer" is Citigroup Inc. and any subsidiary in which Citi owns at least an 80% interest. Citi Markets and Banking, Global Wealth Management, the Global Consumer Group, Citi Alternative Investments and Citi Corporate Center are the Citigroup businesses that participate in the Plans.

For purposes of determining whether you are an eligible employee under the Plans, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, or scheduled days off.

Notwithstanding any provision in the Plans to the contrary, you are eligible to participate in the health care plans if you are receiving severance payments from Citi or a participating employer.

You are not an eligible employee and can not participate in the Plans if:

- your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating employer;
- you are employed by a Citi subsidiary or affiliate that is not a participating employer;
- you are engaged under an agreement that states you are not eligible to participate in the Plans;
- you are a non-resident alien performing services outside the United States; or
- you are classified by Citi as an independent contractor or consultant, or as being employed on a temporary basis.

If you are a U.S. citizen or legal resident employed outside the United States in an expatriate classification, your eligibility will be determined in accordance with practices and procedures established under the Plans.

If you both work for Citi

If both you and your spouse, civil union partner, or qualified domestic partner are employed by Citi or a participating employer, neither of you can be covered both as an employee and a dependent for any Citi benefit plan.

- Medical, dental, and vision care — Each of you may be covered under the medical and dental plans as either an employee or a dependent but not both. Either of you may cover your children, but they cannot be covered by both of you.
- General Purpose Health Care Spending Account ("HCSA") — Either of you may be covered under a Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. However, your civil union partner, or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of section 152 of the Code as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- Limited Purpose Health Care Spending Account ("LPSA")- If either of you enroll in the Citi Basic or Premier High Deductible Health Plan, may be covered under the Limited Purpose Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Neither of you can enroll in the HCSA, and you may only be reimbursed for dental, vision or preventive care expenses under this account. However, your civil union partner or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- Employee Assistance Program – both of you and your dependents will be covered under this program.

For dependents

Your eligible dependents are:

- Your lawfully married same or opposite sex spouse, state-recognized common-law spouse, or state recognized civil union partner (in the states that recognize such unions). If you are legally separated, your spouse is not an eligible dependent unless mandated by state law.
- Each of your children who is unmarried and a "qualifying child" or "qualifying relative" as defined in section 152(c) and 152(d) of the Code, respectively. Generally, a qualifying child up to the age of 18 must have the same principal place of residence as you for more than half the year, must not provide over one-half of his or her own financial support, and a qualifying relative:
  - will attain the maximum age of 19* as of the close of the plan year or
  - will attain the maximum age of 25* as of the close of the plan year, and is a full-time student (meaning the student is enrolled full-time in courses for at least 5 months during the plan year) attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claim Administrator. The names, addresses and phone numbers of the health care Claim Administrators are listed in "Plan information" on page 69.

Generally, for you to have a qualifying relative as described above, **you** must be providing over one-half of your child's financial support.

Please note that insured HMOs made available through the Citi Health Benefit Plan comply with state laws that require less restrictive age and/or income requirements for dependents. These laws apply only to insured health programs and do not apply to the ChoicePlans or other non-insured

(self-funded) programs. States that have these laws include Colorado, Georgia, New Mexico, New Jersey, Pennsylvania, Tennessee, and Utah. For more information, contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

* Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs. You are required to notify the Plans when such events occur in order for your eligible dependents to be eligible for COBRA coverage discussed later in the COBRA section of this document.

To be an eligible dependent, your children must be either:

- Your natural children;
- Your legally adopted children (for purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.);
- Your stepchildren; or
- A child permanently residing in your household for whom you are the legal guardian in accordance with the laws of the state in which you reside. You must provide proof of legal guardianship in writing to the Claim Administrator **upon request**.

Eligible dependents also include an employee's civil union partner/domestic partner and/or his or her dependent children. To be eligible, the children of the civil union partner/domestic partner must meet all the qualifications of eligible dependent children as described in this section. Please note that not all HMOs cover civil union partners/domestic partners or their children. For more specific information, contact your HMO directly.

If one of your eligible dependent children is permanently and totally disabled as defined for purposes of obtaining Social Security benefits and (a) is covered under the Plans before reaching the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claim Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage.

No person will be covered under the Plans both as an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Eligible dependents must be U.S. citizens or legal residents.

Qualified Medical Child Support Orders

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the Plans. In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in

the case of a divorce or separation. Contact the Plan Administrator to receive, free of charge, a detailed description of the procedures for a QMCSO.

Dependent notification

The first time you enroll in Citi benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 19, whether the child is a full-time student or has a mental or physical disability.

If your dependent does not have a Social Security number at this time, you can enter dependent information and report the Social Security number after you obtain it.

You also must keep your dependent information current:

- When you enroll during the annual open enrollment period, you will be prompted to make changes to your dependent information; and
- You must report changes in dependent information to the Benefits Service Center when you want to make changes to your coverage or coverage category as a result of a qualified status change.

Dependents no longer eligible

Your spouse, civil union partner, or qualified domestic partner is eligible for coverage until the last day of the month in which you become legally separated or divorced or submit a Domestic Partnership Termination Form.

Coverage for your dependent children will end:

- The last day of the month in which they:
  - Become employed full time;
  - Get married;
  - Become eligible for coverage under any plan as employees; or
  - Cease to be “eligible dependents” as defined in the previous section of this Plan document.

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citi will pay benefits under the Health Benefit Plan (self-funded plans) for your newborn child from birth through 31 days. (Note that this eligibility provision does not apply to all insured plans; therefore, you should contact the plan for details). However, if you have coverage under any of Citi’s Plans, you must report this family status change to the Benefits Service Center within 31 days of the child’s birth to add the child to your coverage. If you do not report the addition of your child during the first 31 days, benefits will not be payable for the child after the 31 days following the date of the child’s birth, and you will generally have to wait until the next annual open enrollment period to enroll the child in the Plans unless another event occurs that would permit coverage to begin at an earlier time. In this case, no payment will be made for any day of confinement, treatment, services, or supplies given to the child after these initial 31 days after the child’s birth. No other benefit or provision of the Health Benefit Plan will apply to the child.

This includes, but is not limited to, the following provisions:

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Benefits Service Center about a new dependent even if you already have family coverage. Otherwise your new dependent won't be covered.

For civil union partners/domestic partners/same sex spouses

Where available, Citi allows you to cover your civil union partner/domestic partner and/or his or her children in the following plans:

- Health Benefit Plan (civil union partner/domestic partner medical benefits are not available through some HMOs);
- Dental Benefit Plan;
- Health Care Spending Account, provided your civil union partner/domestic partner and eligible dependent child(ren) are considered tax dependents under section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof (note: civil union partner/domestic partners who do not meet section 152 cannot have their claims submitted for reimbursement into the Health Care Spending Account);
- Vision Benefit Plan; and
- Employee Assistance Program.

You cannot cover both a spouse, a civil union partner, and a domestic partner. In states where civil unions are recognized, benefits are to be provided on the same basis as they would be for a married spouse. No affidavit with respect to a civil union relationship is required to enroll a civil union partner in the Plans. However, to obtain benefits on a pre-tax basis for your civil union partner and his/her eligible dependents, you must complete a Certification of Civil Union Partner's Tax Status. Otherwise, such benefits are taxable.

To enroll a domestic partner and/or his or her children, an employee must sign an affidavit affirming that he or she meets Citi's eligibility criteria for domestic partner coverage, and complete a Certification of Domestic Partner's Tax Status. The forms discussed above are available on You @ Citigroup or by calling the Benefits Service Center.

Your domestic partner can be of the same or opposite sex. To qualify for coverage as a domestic partner, you and your domestic partner must meet all of the following criteria:

- You currently reside together and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment (the six months is counted beginning with the date your divorce is final or the date you report your divorce to the Benefits Service Center, whichever is later);
- You have mutually agreed to be responsible for each other's common welfare;
- You are both at least 18 years of age and mentally competent to consent to contract;

- You are not related by blood to a degree of closeness that would prohibit marriage if you and your partner were of opposite sexes;
- Neither you nor your partner is legally married to another person; if you're still married, legally separated or getting divorced, you can't add a domestic partner to your coverage until the later of six months from the date of your divorce or when you notify the Benefits Service Center that you're divorced.
- Neither you nor your partner is in a domestic partner relationship with anyone else
- You are in a relationship that is intended to be permanent and in which each of you is the sole domestic partner of the other; and
- You are financially interdependent, or your partner is dependent on you for financial support.

The Company may require you to provide evidence of your financial interdependence (or domestic partner's financial dependence) by providing two or more of the following documentation:

- A joint mortgage or lease;
- Designation of the Domestic Partner as beneficiary for life insurance or retirement benefits;
- Joint wills or designation of the Domestic Partner as executor and/or primary beneficiary;
- Designation of the Domestic Partner as your agent under a durable power of attorney or health proxy;
- Ownership of a joint bank account, joint credit cards or other evidence of joint financial responsibility; or
- Other evidence of economic interdependence.

To qualify for coverage, your domestic partner's unmarried child(ren) must:

- Be the biological or adopted child of your domestic partner, a child for whom your domestic partner has legal guardianship, or a child who has been placed in your home for adoption; and
- Satisfy all other qualifications of eligible dependent children as described above.

Your domestic partner and his or her unmarried children must be U.S. citizens or legal residents to qualify for coverage.

Termination of relationship

If you have enrolled your domestic partner and his or her children for medical, dental, and/or vision care coverage and you terminate your domestic partnership, you must notify Citi by completing a Termination of Domestic Partnership Form within 31 days of the event. Contact the Benefits Service Center for this form. As a result, your domestic partner will be eligible to continue medical, dental, vision care, and/or Health Care Spending Account, if applicable, coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses, civil union partners and other covered dependents, excluding domestic partners and their children. See "COBRA" on page 27 for more information.

If you enroll a partner and terminate the domestic partner relationship, you must wait six months before enrolling a new domestic partner in a medical, dental, or vision care plan sponsored by Citi.

Enrollment

You can enroll in Citi coverage within 31 days of the time you first become eligible or during the annual open enrollment period. The coverage available to you will be listed on your enrollment materials along with the enrollment deadline and how to enroll. You can enroll in any or all of the plans offered to you.

For the medical and dental plans, you must choose a "coverage category." The four coverage categories are:

- Employee only;
- Employee + child(ren);
- Employee + spouse, civil union partner, or domestic partner; and
- Employee + family.

You can choose a different coverage category for medical and dental. For example, you might enroll in "Employee only" coverage for medical, since your spouse has medical coverage at his or her employment and "Employee + spouse" for dental coverage if your spouse's employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your total compensation band as defined in "Your contributions" on page 15. You will find your costs in your enrollment materials.

If you elect vision care coverage, you must also designate a level of coverage (one person, two people, or three or more people). You do not need to be enrolled in the vision care plan to enroll a dependent for vision care coverage.

Other coverage

If you are eligible to enroll in coverage elsewhere, for example, through a spouse's, civil union partner's or other employer's plan, you can compare the Citi coverage and costs with the other coverage. You may decide to enroll in some plans offered through Citi and some from the other source. For example, you might enroll in medical coverage elsewhere and in Citi dental coverage.

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits." See "Coordination of benefits" on page 18 for the guidelines on whose plan pays first.

When coverage begins

If:	Then:
You enroll for yourself and your eligible dependents when first eligible.	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your date of hire or date of eligibility.
You enroll for yourself and your eligible dependents during the annual open enrollment period.	Coverage will begin on January 1 of the following year.
You enroll in medical, dental, vision care, and/or spending account coverage for yourself or a new dependent within 31 days of a qualified status change.	Coverage for yourself or your dependent(s) will begin on the date of the qualified status change, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

Changing your coverage

During the year, you may want to change your coverage or coverage category. Citi has specific rules about when you can change your coverage.

For medical, dental, and vision care coverage and the Health Care Spending Account — the coverages you pay for with before-tax dollars — you can make changes only during the open enrollment period or as a result of certain events, such as marriage, the birth or adoption of a child, divorce, or the death of a dependent. These events are called qualified status changes. You must make any qualified status change-related changes to your coverage within 31 days of the event. See "Qualified status changes" on page 12.

Type of coverage:	When you can change your coverage or coverage category:
Medical and dental	The annual open enrollment period or within 31 days of a qualified status change.
Vision care	The annual open enrollment period or within 31 days of a qualified status change.
General Purpose Health Care Spending Accounts/Limited Purpose Health Spending Accounts	The annual open enrollment period or within 31 days of a qualified status change.

Qualified status changes

The rules regarding qualified status changes apply to coverage elections you make for your medical, dental, vision care, the health care spending account, and the Limited Purpose Health Care Spending Account coverage. In general, the benefit plans and coverage levels you choose at open enrollment remain in effect for the following calendar year. However, you may be able to change your elections between annual enrollment periods if you have a qualified status change or other applicable event, as further explained below.

The following is a list of qualified status changes that will allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status**. Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment;
- **Domestic partnership status**. You enter into or terminate a domestic partnership;
- **Number of dependents**. Any event that changes your number of tax dependents, including birth, death, adoption, and placement for adoption;
- **Employment status**. Any event that changes your, your spouse's, or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status**. Any event that causes your tax dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence**. A change in the place of residence for you, your spouse, or another dependent if outside your medical or dental plan's network service area.

Coverage changes will be administered in accordance with applicable Treasury Regulations (Treasury Regulation section 1.125-4).

Consistency requirements

The changes you make to your medical, dental, vision care, and spending account coverages must be "due to and consistent with" your qualified status change. To satisfy the federally required "consistency rule," your qualified status change and corresponding change in coverage must meet both of the following requirements.

Effect on eligibility

The qualified status change must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified status change results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

Corresponding election change

The election change must correspond with the qualified status change. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel medical coverage only for that dependent. Additionally, you may increase or start contributions to a Health Care Spending Account or a Limited Purpose Health Care Spending Account if you add a dependent.

The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage & cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below. However, in no event will any cost or coverage event allow you to make a change to your Health Care Spending Account or your Limited Purpose Health Care Spending Account election.

Coverage events

If Citi adds or eliminates a plan option in the middle of the plan year, or if Citi-sponsored coverage is significantly limited or ends, you and your eligible dependents can elect different coverage in accordance with Internal Revenue Service ("IRS") regulations.

For example, if there is an overall reduction under a plan option that reduces coverage to participants in general, participants enrolled in that plan option may elect coverage under another option providing similar coverage (if the other plan option permits). Additionally, if Citi adds an HMO or other plan option midyear, participants can drop their existing coverage and enroll in the new plan option (if the new plan option permits). You and/or your eligible dependents may also enroll in the new plan option even if not previously enrolled for coverage at all (if the new plan option permits).

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Citi), you may make a corresponding midyear election change.

If another employer's plan allows your spouse, civil union partner, or other dependent to make a mid-year change to his or her elections in accordance with IRS regulations, you may make a corresponding midyear election change to your coverage.

Cost events

You must contact Citi within 31 days of a cost event. Otherwise, your next opportunity to make changes will be the next enrollment period or when you have a qualified status change or other applicable event, whichever occurs first.

If your cost for medical, dental, or vision care coverage increases or decreases significantly during the year, you may make a corresponding election change. For example, you may elect another plan option with similar coverage, or drop coverage if no coverage is available. Additionally, if there is a significant decrease in the cost of a plan during the year, you may enroll in that plan, even if you declined to enroll in that plan earlier.

Any change in the cost of your plan option that is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Other rules

Medicare or Medicaid entitlement: You may change an election for medical coverage midyear if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your medical/dental coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding medical/dental coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act: You may drop medical (including the Health Care Spending Account and the Limited Purpose Health Care Spending Account), dental, and vision care coverage midyear when you begin an unpaid leave, subject to the provisions of the Family and Medical Leave Act (FMLA). If you drop coverage or if you fail to make payments for benefit coverage during your FMLA leave, when you return from the FMLA leave, you have the right to be reinstated to the same elections you made prior to taking your FMLA leave.

Special note regarding civil union partner/domestic partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a civil union partner/qualified domestic partner. However, IRS rules generally do not permit you to make a midyear change "on a before-tax basis" for such events unless they involve a tax dependent. Thus, if you make a midyear change due to an event involving your civil union partner/domestic partner, that change must generally be made "on a post-tax basis," unless your civil union partner/domestic partner can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your civil union partner/domestic partner makes an election change under his or her employer's plan in accordance with IRS regulations.) Please see IRS Publication 17, **Your Federal Income Tax**, for a discussion of the definition of a tax dependent. The publication is available at www.irs.gov/formspubs/index.html.

Changing your coverage status

You must make changes to your health benefits within 31 days of a qualified status change by calling the Benefits Service Center. The change will be effective on the date of your status change.

Your contributions

Your contributions for medical, dental, and vision care are based on the plan chosen and the coverage category. Your medical contribution also depends on your total compensation and which total compensation band applies to you. The required employee contributions to the medical, dental and vision plans increase as compensation increases. The compensation bands for 2009 are shown in the table below. Contributions for your Health Care Spending Account or your Limited Purpose Health Care Spending Account are determined by your contribution amount and not by your compensation band.

Total compensation bands on which employee contributions for medical coverage are based:
$20,000 or less
$20,001 – $25,000
$25,001 – $40,000
$40,001 – $60,000
$60,001 – $80,000
$80,001 – $100,000
$100,001 – $150,000
$150,001 – $250,000
$250,001 – $500,000
$500,000 +

For purposes of calculating your medical cost and coverage amounts, total compensation is determined each year and will apply for the entire calendar year.

With respect to the current plan year, total compensation consists of (a) the annual rate of regular base pay as of July 1 of the calendar year (the "Prior Year") which precedes the current plan year; (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any non-annual cash bonuses paid during the calendar year which precedes the Prior Year; and (d) any annual bonus earned during the calendar year which precedes the Prior Year and that is paid in cash or in the form of an equity award under the Core Capital Accumulation Program during such calendar year or the Prior Year.

Notwithstanding the foregoing, total compensation shall include severance payments for purposes of individuals who participate in the Plan post-employment while receiving severance pay. The list of items that constitute total compensation under the Plan is exclusive, and shall not include any extraordinary payments, including but not limited to those related to settlements or forgivable loans or any other amounts, unless specifically set forth in the plan document or in an agreement or statement of policy approved or authorized by the Senior Human Resources Officer of Citigroup Inc. or his or her delegate."

For example, the total compensation for the 2009 plan year includes:

- Base pay annualized as of July 1, 2008;
- Commissions paid from January 1 – December 31, 2007;
- Cash bonuses paid from January 1 – December 31, 2007 (excluding any annual bonus);
- 2007 annual bonus (paid in 2007 and/or 2008); and
- Short-Term Disability benefits paid from January 1, 2007 through December 31, 2007, for employees paid on commissions only.

If you were rehired on or after July 1, 2008, your total compensation is your annualized base pay as of your date of hire.

For new hires: your annualized base pay as of your date of hire and any guaranteed bonus will be considered in the calculation of Total Compensation for benefits purposes.

For Global Wealth Management Financial Advisors

In your first year of employment, your compensation is considered to be $60,000. If you earned more than $60,000 at a previous employer in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 Wage and Tax Statement to your HR representative within 30 days of your hire date.

If you decide to provide a copy of the form, your Basic Life insurance amount will be set at the higher amount (up to $200,000) shown on the form. Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions also will be based on the higher amount.

Your decision to have your total compensation set at $60,000 or based on your Form W-2 amount is irrevocable.

Before-tax contributions

When you choose coverage that requires a payroll contribution, most of your contributions are made with before-tax dollars. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. Contributions may, however, be subject to state or local income taxes in certain jurisdictions.

Social Security taxes

Each year you pay Social Security taxes on a certain level of your earnings, called the taxable wage base. Since the before-tax dollars you use for some of your plan contributions are not considered part of your pay for Social Security tax purposes, your Social Security taxes will also be reduced if your pay falls below the taxable wage base after these before-tax dollars are subtracted from your total earnings. In this case, your future Social Security benefit may be smaller than if after-tax dollars were used for those purposes.

Civil Union Partners/Domestic partners

The cost of coverage for a civil union partner/domestic partner is the same as the cost for a spouse. The cost of coverage for a civil union partner's/domestic partner's child(ren) is the same as the cost for a dependent child. For the cost of civil union partner/domestic partner coverage in a particular plan, call the Benefits Service Center.

If your civil union partner/domestic partner and his or her child(ren) qualify as your dependents under section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, your contributions for civil union partner/domestic partner medical, dental, and/or vision care coverage will be taken on a pre-tax basis. However, if your civil union partner/domestic partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, you will pay for their medical, dental, and/or vision care coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your civil union partner/domestic partner in Citi coverage.

If your civil union partner/domestic partner does NOT qualify as a tax dependent: If your civil union partner/domestic partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, the cost of any medical, dental, and/or vision care coverage for your civil union partner/domestic partner and/or his or her child(ren) is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income.

Example: Total Citi cost for Employee Only coverage is $450 per month. Total Citi cost for Employee Plus Spouse/Domestic Partner/Civil Union Partner coverage is $900;

The $450 cost for partner coverage will be treated as taxable income to you. This amount is known as imputed income, and you will be taxed on this amount.

You will see a line item on your pay statement that shows $450 in imputed income. The taxable amount of that benefit (as determined by Citi's payroll department) will be deducted from your pay. In this example, $100 in taxes may be deducted from your pay for the $450 in imputed income.

If your civil union partner/domestic partner qualifies as a tax dependent: If your civil union partner/domestic partner and his or her child(ren) qualify as dependents for federal income tax purposes as described above, your contributions for their medical, dental, and/or vision care coverage will be taken before taxes are withheld, and there are no tax implications for you.

Since the tax requirements are complex, you should consult a tax professional for advice on your personal situation.

To review the qualifications of a section 152 dependent, see IRS Publication 501 at www.irs.gov/formspubs/index.html.

Coordination of benefits

Coordination of benefits provisions apply to the Health Benefit Plan and the Dental Benefit Plan only and are described in this section.

All payments under these Plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under the applicable Citi Plan will be determined. One of the plans involved will pay benefits first — the primary plan — and the other plan(s) will pay benefits next — the secondary plan(s).

The following definitions apply to terms used in this section:

- **Allowable expense**: Includes any necessary, reasonable, and customary expense that would be covered in full or in part under the Citi Plan. When an HMO provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.
- **Plan**: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured), medical care components of group long-term care contracts (such as skilled nursing care),

medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or other governmental benefits, as permitted by law.

- **Primary plan**: A benefit plan that has primary liability for a claim.
- **Secondary plan**: A benefit plan that adjusts its benefits by the amount payable under the primary plan.

The Citi Plan will be the primary plan on claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, civil union partner or domestic partner, if the same is not covered as an employee by another plan; and
- For your dependent children, the birthdays of the parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes first in the calendar year will be considered primary coverage (For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your children). If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

When the Citi Plan is the primary plan, it will pay benefits first. Benefits will be calculated according to the terms of the Plan and will not be reduced due to benefits payable under other plans.

When the Citi Plan is the secondary plan, benefits under the Citi Plan may be reduced. The Claim Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan than the Citi Plan would have paid alone.

When the Citi Plan is secondary and the patient is covered under an HMO, benefits under the Citi Plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO.

When a child is claimed as a dependent by parents who are separated or divorced, the primary plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. When a child's parents are separated or divorced and there is no court decree, then benefits will be determined in the following order:

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child;
- The plan of the spouse of the parent not having custody of the child.

In the event that a legal conflict exists between two plans as to which is primary and which is secondary, the plan that has covered the patient for the longer time will be considered primary. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered primary.

With regard to any governmental health care coverage provided during a military leave, any health care coverage provided under the Citi Plans (including any such coverage required under USERRA, COBRA or other law or under any Citi military leave policy) will be secondary to the governmental health care coverage.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and are covered under the Citi Plan, the Citi Plan continues to be the primary plan. The Citi Plan is primary for the following situations:

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citi Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

If you or a covered family member becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

No-fault automobile insurance

In states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. All medical expenses related to the automobile accident should be submitted to the automobile insurance carrier first. The Citi Plan will pay covered expenses not payable under the no-fault automobile insurance according to the coordination of benefit rules discussed above.

Facility of payment

When benefit payments that would have been made under a Citi Plan have been made under another plan, the Citi Plan has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the Citi Plan and, to the extent of such payments, the Citi Plan's obligation to pay benefits will be satisfied.

Right of recovery

The Citi Plan has the right to recover any payment made in excess of the maximum amount payable under this provision. The Citi Plan may recover from one or more of the following entities in an effort to make the Plan whole:

- Any persons it paid or for whom payment was made;
- Any insurer, and any other organization; or
- Any entity that was thereby enriched.

Release of information

Certain facts are needed to apply the rules of this provision. The Claim Administrator has the right to decide which facts are needed. The Claim Administrator may get the needed facts from or give them

to any other organization or person. The Claim Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claim Administrator will determine the information necessary to operate this provision.

Citi will use and disclose health care information that relates to Plan participants only as appropriate for Plan administration and only as permitted by applicable law.

Recovery provisions

Recovery provisions apply to the Health Benefit Plan and the Dental Benefit Plan and are described in this section.

Refund of overpayments

Whenever payments have been made by a Plan with respect to covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision, the covered person(s) must make a refund to the Plan in the amount paid in excess of the amount payable under the Plan and help the Plan obtain the refund from another person or organization, as applicable.

If the covered person(s) or any other person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount it should have been repaid. In the case of recovery from a source other than the Plan, the refund equals the amount of recovery up to the amount paid under the Plan. The Plan may have other rights in addition to the right to reduce future benefits.

Reimbursement

This section applies when a covered person recovers damages, by settlement, verdict, or otherwise, for an injury, sickness, or other condition. If the covered person has made such a recovery, including a recovery from an insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the Plans do pay or provide benefits for such an injury, sickness, or other condition, and the covered person subsequently recovers damages by settlement, verdict or otherwise — or the legal representatives, estate, or heirs of the covered person — will promptly reimburse the Plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdicts, or insurance proceeds received by the covered person (or by the legal representatives, estate, or heirs of the covered person) to the extent that medical benefits have been paid for or provided by the Plan to the covered person.

If the covered person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the covered person has received benefits from the Plan, the Plan must be reimbursed first. In other words, the covered person's recovery from a third party may not compensate the covered person fully for all of the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the covered person receives.

The covered person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action, or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party. The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health Plan maintained by Citi or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

In order to secure the rights of the Plan under this section, the covered person hereby:

- Grants to the Plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by the covered person to the extent of all benefits provided in an effort to make the Plan whole; and
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage. The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.

The covered person will cooperate with the Plan and its agents and will:

- Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
- Provide any relevant information; and
- Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the covered person does not sign and deliver any such documents for any reason (including but not limited to the fact that the covered person was not given an agreement to sign or is unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the Plan. If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

This section applies when another party is, or may be considered, liable for a covered person's injury, sickness, or other condition (including insurance carriers who are so liable) and the Plan has provided or paid for benefits.

The Plan is subrogated to all the rights of the covered person against any party liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Plan under this section.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. However, if you fail to perform the obligations stated in this section you may be rendered liable to the Plan for any expenses the Plan may incur including reasonable attorneys fees, in enforcing its rights under this Plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

When coverage ends

For any of the Plans, your coverage automatically will terminate on the earliest of the following dates:

- The date the Citi Plan terminates;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which you retire, die, or otherwise cease to be eligible for coverage;
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under the Citi Plan. Coverage for eligible dependents who have not reached their lifetime maximum will not be affected; or
- Midnight of the last day of employment if your termination is due to gross misconduct.

Your eligible dependent's coverage automatically will terminate on the earliest of the following dates:

- Midnight of the last day of the month in which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage (which termination must be in accordance with Plan terms and applicable law);
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage. In general, coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student, whichever occurs first. Coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job;
- The date the eligible dependent(s) is covered as an employee under the Plan;
- The date the eligible dependent(s) is covered as the dependent of another employee under the Plan;

- The date the eligible dependent(s) enters the armed forces of any country or international organization;
- The date the dependent is no longer eligible for coverage under a QMCSO; or
- Midnight of the last day of the month in which you become legally separated or divorced (this applies to coverage for your spouse, civil union partner, or domestic partner).

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" on page 27 for more information.

Coverage when you retire

You could be eligible for retiree health care coverage if your combined age and years of service equal at least 60 and (ii) if you have attained a minimum age of 50 and with at least 5 years of service when you leave Citi. For more information on eligibility for this coverage, contact the Benefits Service Center. You will be required to contribute to the cost of coverage.

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care plan coverage and participation in the Health Care Spending Account or the Limited Purpose Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions. After you have been disabled for 13 weeks, if you are still disabled and/or long-term disability coverage is pending, your coverage will remain in effect and you will be billed for benefits.

If you are totally disabled, coverage will continue as follows.

Medical coverage* will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions after the short-term disability coverage ends. After that, you may continue medical coverage by making the same contributions as active employees, based on your years of service as shown in the table below. (After 52 weeks of disability, your employment will be terminated.) For purposes of the Plan, a year of service is any 12 consecutive months in which you have provided 1,000 hours of service.

Years of recognized Citi service as of week 52 from STD date	Medical continuation period after week 52 (the termination of your employment)
Less than two years	Six months
Two years to less than five years	Equal to years of service (including fractions)
Five years or more	As long as you are disabled or have not reached the maximum age limit to receive LTD benefits

At the end of the period, you may continue coverage through COBRA. The medical coverage continuation period after your employment terminates after 52 weeks of receiving disability benefits is considered part of the period of COBRA-continued coverage.

Dental coverage will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions after the short-term disability coverage ends. You may then continue coverage through COBRA.

Vision care coverage will continue for the 13-week period of short-term disability. No contribution is required during this time. You may then continue coverage through COBRA.

General Purpose Health Care Spending Account/Limited Purpose Health Care Spending Account participation will continue for the 13-week period of short-term disability. No contribution is required during this time. You may then continue coverage through COBRA for the remainder of the calendar year.

* In the event LTD was not elected and/or preexisting condition causes a denial of LTD benefits, the schedule outlined will apply in those cases and the disability carrier will monitor the disability claim.

Coverage if you take a leave of absence

If you go on an approved leave of absence, you may continue coverage under the medical, dental, vision care, and health care spending account. Your reduction in hours (less than 20 hours per week) constitutes a COBRA qualifying event under the plans. See “COBRA” on page 27 continuation of coverage. You will pay at a rate under the plans determined under a policy established by the Committee or Citi.

Continuing coverage during FMLA

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are eligible for FMLA, you may take up to a total of 13 weeks of leave each calendar year (except where state law mandates differently).

If you take an unpaid leave of absence that qualifies under FMLA, medical, dental, and vision care coverage for you and your dependents and your participation in the HCSA/LPSA (through the end of the calendar year for HCSA/LPSA)may continue as long as you agree to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You will be billed directly.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may reenroll when you return from your leave. Your coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave, you will be entitled to purchase COBRA continuation coverage for your medical, dental, vision and Health Care Spending Account benefits. If your employment is terminated while you are on an FMLA leave, you may also be eligible to continue your insurance coverage under COBRA.

During an FMLA leave, you have access to the entire amount of your Health Care Spending Account annual election, less any prior reimbursements that you have received, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level

in effect before your FMLA leave or electing to increase your contribution level to "make up" for the contributions you missed during your leave. If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave. Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

Continuing coverage during military leave – Citi policy

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage (including medical, dental, vision, and Health Care Spending Account) in accordance with the terms and conditions of the Citi Military Leave Policy. The policy generally provides for paid leave and subsidized employer contributions to health care continuation coverage for the duration of your leave, and is more generous in many respects than what federal law currently requires of employers. For a copy of the policy, please visit Citi.net. From the home page, use the search function and enter "military leave." Then click on the most current policy. Employee contributions will be deducted automatically from your pay.

The start of a military leave is considered a qualified change in status. As a result, you may stop coverage under any of the health and welfare benefit plans in which you are enrolled or, if you have not previously done so, you may enroll in certain coverage.

You must contact the Benefits Service Center to enroll or stop coverage. If you do not contact the Benefits Service Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave (unless coverage stops automatically when your leave ends).

You can participate in any annual enrollment periods that occurs while you are on a military leave. If you are unable to make elections during annual enrollment, your elections will continue in effect until you return from your leave when you can make new elections for all health and welfare plans. If you elect to discontinue coverage while on a leave, you will have the right to re-enroll when you return to work.

Contact the Benefits Service Center or contact your HR representative for more information about a military leave.

Continuing coverage during military leave – no Citi policy

In the event such policy expires or otherwise ceases to remain in effect, you are still entitled to continue coverage for you and your dependents under the Health Benefit Plan, the Dental Benefit Plan, the Vision Benefit Plan and the HCSA/LPSA for the length of your leave up to 24 months in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as long as you give Citi notice of your leave as soon as practicable (advance notice, if possible). Your payments would be on an after-tax basis.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both company and employee

contributions) necessary to cover an employee who does not go on military leave. Your other benefits will be terminated at the beginning of your military leave.

If you take a military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plan Administrator determines whether an exclusion or waiting period applies once you are reinstated to the plan. The Plan Administrator may take other steps to administer the Plans in accordance with USERRA and the Department of Labor regulations thereunder.

If you are on military leave for less than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage, as your eligibility for COBRA will begin on the date your leave ends.

Call the Benefits Service Center or contact your HR representative for more information about a military leave.

Coverage for surviving dependents

When an active employee dies, and his or her surviving covered spouse or civil union partner and/or dependent children were enrolled in active coverage at the time of the employee's death, the covered individuals will be eligible to continue health care coverage for six months at no cost.

- If the employee was not eligible for retiree health care coverage at the time of death, medical and dental coverage will continue for the surviving spouse and/or dependent children for six months at no cost. In order to have the six months of free medical and dental coverage for your spouse and dependents, they must elect COBRA continuation of coverage. After the six-month period, they will be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period.
- If the employee was eligible for retiree health care coverage at the time of death, medical and dental coverage will continue for the covered spouse and/or dependents for six months at no cost pursuant to the COBRA election noted above. At the end of the six months, the surviving spouse and/or dependent children can either continue COBRA coverage or elect retiree health care coverage. Retiree health care coverage is provided on the same terms as it is for a retired employee.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events"). The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. Citi reserves

the right to terminate your coverage retroactively if you are determined to be ineligible for COBRA under the terms of the Plans.

You will have to pay the entire premium plus a 2% administrative fee for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

Who is covered

If you are covered by a Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period, and you do not return to work.

If you are the spouse, civil union partner or domestic partner of an employee and are covered by a Citi-sponsored medical, dental, or vision care plans, or HCSA/LPSA on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Citi-sponsored group health plan for any of the following four reasons:

- The death of your spouse/civil union partner/domestic partner;
- The termination of your spouse's/civil union partner's/domestic partner's employment (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment;
- Divorce or legal separation from your spouse/civil union partner or termination of a domestic partnership; or
- Your spouse/civil union partner/domestic partner becomes entitled to Medicare.

If you are a covered dependent child of an employee covered by a Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plans is lost for any of the following five reasons:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The employee's divorce or legal separation;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be a "dependent child" under the Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the employer-

sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption, within 31 days of the event.

If the covered employee fails to notify Citi in a timely fashion (60 days from the date coverage was lost), the covered employee will not be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries but may be added to the employee's continuation coverage.

Separate Elections: Each qualified dependent has an independent right to elect COBRA coverage. For example, if there is a choice among types of coverage, each qualified dependent who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects.

Your duties

Under the law, the employee or a family member has the responsibility to inform Citi of a divorce, legal separation, or a child losing dependent status under the Citi-sponsored medical, dental, or vision care plan, or HCSA/LPSA. This notice must be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event).

If the employee or a family member fails to provide this notice to Citi during this 60-day notice period, any family member who loses coverage will not be offered the option to elect continuation coverage. The notice must be in writing. Send the notice to:

If you're an employee of any Citi business
Citi Service Center P.O. Box 56710 Jacksonville, FL 32241-6710

When Citi is notified that one of these events has happened, Citi, in turn, will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Citi's duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage:

- The employee's death or termination (for reasons other than gross misconduct),

- A reduction in the employee's hours of employment, or
- The employee's entitlement to Medicare.

Electing COBRA

To elect or inquire about COBRA coverage, contact the Benefits Service Center.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after Citi provides you notice of your right to elect continuation coverage. **An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.**

If you choose continuation coverage, Citi is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for a minimum of 18 months if you lost group health coverage because of a termination of employment or reduction in hours. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent's child's losing eligibility as a dependent child, COBRA continuation coverage is available for up to 36 months.

Additional qualifying events (such as your death, divorce, legal separation, or Medicare entitlement or your child's loss of dependent status) may occur while the continuation coverage is in effect.

If you lost coverage because of a termination of employment or a reduction in hours, these events can (but do not always) result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You must notify Citi if a second qualifying event occurs during your continuation coverage period.

When coverage ends, generally you can't convert your coverage to an individual medical policy. However, some HMOs do offer conversion to individual coverage. Contact your HMO directly.

Special Rule for HCSA/LPSA: Except as required by law, the duration of COBRA continuation coverage for the HCSA/LPSA will not extend beyond the plan year in which the qualifying event occurred.

Special Rules for Disability: The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified dependents due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified dependent must inform Citi within 60 days of the Social Security determination of disability and

before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform Citi of this redetermination within 30 days of the date it is made, at which time the 11-month extension will end.

If a qualified beneficiary is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

If you become entitled to Medicare: If you lose coverage (medical, dental, or vision care plan, or Health Care Spending Account) due to your termination of employment or reduction in hours and you become entitled to Medicare less than 18 months before the qualifying event, your eligible family member's COBRA coverage will not end before 36 months from the date you become covered by Medicare.

Early termination of COBRA

The law provides that COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any person who elected COBRA for any of the following five reasons:

- Citi no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any preexisting condition of that covered individual;
- The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the disability carrier that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Citi that you are not returning at the end of the leave; or
- The end of the leave, assuming you do not return to work.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave.

Cost of coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, Citi will notify you of any changes in the cost.

The initial payment for continuation coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days.

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA administrator at the address listed below. Also, if your marital status has changed, or you, your spouse or a dependent have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the Plans, you must notify the COBRA administrator in writing immediately at the address listed below.

All notices and other communications regarding COBRA and the Citi-sponsored group health plans should be directed to:

ADP COBRA Services
P.O. Box 27478
Salt Lake City, UT 84127-0478

Or you may call 1 800 422 7608.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plans excluding the Premier and Basic High Deductible Health Plans.

This notice, required by Medicare to be delivered to Medicare-eligible individuals, contains information about your current prescription drug coverage with Citi and new prescription drug coverage available to people with Medicare. Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage ceases to be "creditable coverage." You may request another copy of this notice by calling ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

Prescription drug coverage and Medicare

Starting January 1, 2006, prescription drug coverage through Medicare prescription drug plans became available to everyone with Medicare. This coverage is offered by private health insurance companies, not directly by the federal government. All Medicare prescription drug plans provide at least a "standard" level of coverage set by Medicare. Some plans also might offer more coverage for a higher monthly premium.

"Creditable coverage"

You have prescription drug coverage through your Citi medical plan. Citi has determined that your Citi prescription drug coverage is "creditable coverage" because, on average for all plan participants, Citi prescription drug coverage is expected to pay in benefits at least as much as the standard Medicare prescription drug coverage will pay. Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Understanding the basics

It is up to you to decide what prescription drug coverage option makes the most financial sense for you and your family given your personal situation. If you are considering the option of joining a Medicare prescription drug plan available in your area, you need to carefully evaluate what that plan has to offer vs. the coverage you have through your Citi medical plan. Before you decide to join a Medicare prescription drug plan, be sure you understand the implications of doing so.

You have prescription drug coverage under your current Citi medical plan. Your prescription drug coverage under the Citi medical plan is considered primary to Medicare, if you are a current Citi employee. This means that your Citi plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in a Citi medical plan, you should consider how Citi plan coverage would affect the benefits you receive under the Medicare

prescription drug plan. If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date if you so choose. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Your existing Citi coverage is, on average, at least as good as standard Medicare prescription drug coverage (this is your "creditable" coverage). As a result, you can keep your current Citi coverage and not pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare.

In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period. If you drop or lose your coverage with Citi and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

You can obtain more information about Medicare prescription drug plans from these sources:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for the telephone number).
- See the "Medicare & You" handbook which Medicare mails to you each year.
- Call 1-800-MEDICARE (1-800-633-4227); for TTY service, call 1-877-486-2048.

Do you qualify for "extra help" from Medicare based on your income and resources?

You can find Medicare's income level and asset guidelines at http://www.cms.hhs .gov/MedicaidGenInfo/ or by calling 1-800-MEDICARE (1-800-633-4227). If you qualify for assistance, visit the Social Security Web site at www.socialsecurity.gov or call 1-800-772-1213 to request an application. **For more information about this notice**, Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative. For text telephone service, call the National Relay Services at "711." Then call ConnectOne at 1-800-881-3938 as instructed above.

Non-Creditable Coverage Disclosure Notice

For employees and former employees enrolled in the Citi High Deductible Health Plans (Basic and Premier)

This notice, required by Medicare to be delivered to Medicare-eligible individuals[1], contains information about your current prescription drug coverage with Citigroup and prescription drug coverage available to people with Medicare.

Keep this Notice. Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Citigroup and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citigroup prescription drug coverage changes such that the coverage becomes "creditable coverage." You may request another copy of this notice by calling ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

Prescription drug coverage and Medicare

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

"Non-Creditable Coverage."

- Citigroup has determined that the prescription drug coverage offered by the Basic and Premier High Deductible Health Plans are, on average for all plan participants, not expected to pay out as much as standard Medicare prescription drug coverage pays and is considered Non-Creditable Coverage. This is important, because most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Citigroup high deductible health plans.

Understanding the basics

- You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join. Read this notice carefully - it explains your options.

[1] Citigroup is required by law to distribute this notice to both current and former employees who are enrolled in Citigroup coverage and who may be Medicare eligible. Generally, you become eligible for Medicare as a result of reaching age 65 or as a result of disability.

- Consider joining a Medicare drug plan. You can keep your coverage from the Citigroup high deductible health plans. You can keep the coverage regardless of whether it is as good as Medicare drug plan. However, because your existing coverage is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.
- You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15th through December 31st. This may mean that you may have to wait to join a Medicare drug plan and that you may pay a higher premium (a penalty) if you join later. You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. If you lose your prescription drug coverage under one of the Citigroup high deductible health plans, through no fault of your own, you will be eligible for a sixty (60) day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan because of your lost coverage. In addition, if you lose or decide to terminate your coverage under the Citigroup prescription drug plan; you will be eligible to join a Medicare prescription drug plan at that time under the SEP, as well.

You need to make a decision.

When you make your decision, you should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to enroll in a Medicare prescription drug plan and you are an active employee or the family member of an active employee, you may also continue your Citigroup coverage. In this case, the Citigroup prescription drug program will continue to be the primary payer as it had before you enrolled in a Medicare prescription drug plan. This means that Medicare will pay for permitted coverage, as applicable, after Citigroup pays its benefit. If you waive or drop Citigroup prescription drug coverage, Medicare will be your only payer.

If you do decide to join a Medicare drug plan and drop your Citigroup prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You should also know that if you drop or lose your coverage with Citigroup and don't join a Medicare prescription drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium may go up by at least 1% of the base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For more information about Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www .socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice

Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

For text telephone service: Call the National Relay Service at "711." Then call ConnectOne at 1-800-881-3938 as instructed above.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Citigroup changes. You also may request a copy.

Your HIPAA rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

HIPAA restricts the ability of group health plans to exclude coverage for preexisting conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described below.

Creditable coverage

Under HIPAA, when you and your dependents no longer have Citi medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment

and your new employer's plan has a preexisting condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Your special enrollment rights

If you decline to enroll for Citi medical coverage for yourself and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citi coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member loses eligibility under another plan or because COBRA coverage has ended. In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you also may be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you will have to wait until the next open enrollment period — or have another qualified status change or special enrollment right — to enroll.

To meet IRS regulations and plan requirements, Citi reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying event.

Your right to privacy and information security

HIPAA requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the Plans to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the Plans' privacy notice for more information. You can obtain a copy of the notice by contacting the Benefits Service Center.

The Plan Sponsor shall use and disclose individually identifiable health information ("Protected Health Information") as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule"), only to perform administrative functions on behalf of the Plans. The Plan Sponsor shall not use or disclose such information for any purpose other than as permitted to administer the Plans or as permitted by applicable law.

The Plans shall disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plan document has been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from any of these plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor shall not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The

Plan Sponsor shall report to the Plans any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plan Sponsor shall make available Protected Health Information to the Plans for purposes of providing access to individuals' Protected Health Information in accordance with 45 C.F.R. sec. 164.524. The Plan Sponsor shall make available Protected Health Information to these plans for purposes of amending the Plans and shall incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. sec. 164.526. The Plan Sponsor shall make available Protected Health Information and any disclosures thereof to these plans as required to provide an accounting of disclosures in accordance with 45 C.F.R. sec. 164.528.

The Plan Sponsor shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plans with the HIPAA Privacy Rules; the Plan Sponsor shall notify the Plans of any such request by the Secretary prior to making such practices, book, and records available. The Plan Sponsor shall, if feasible, return or destroy all Protected Health Information received from the Plans that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosures were made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor shall ensure that only its employees or other persons within the Plan Sponsor's control that participate in administering the Plans shall be given access to Protected Health Information to be disclosed, including those employees or persons who receive Protected Health Information relating to Payment, Health Care Operations (as defined in the HIPAA Privacy Rules) of, or other matters pertaining to the Plans in the ordinary course of the Plan Sponsor's business and perform Plan administration functions. The Plan Sponsor agrees to demonstrate to the satisfaction of the Plans that it has put in place effective procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.

In addition, the Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic Protected Health Information (as defined in the applicable HIPAA regulations) that it creates, receives, maintains or transmits on behalf of the Plans. The Plan Sponsor will also support the "firewall" described in the last sentence of the preceding paragraph with reasonable and appropriate security measures. The Plan Sponsor shall ensure that any agents or subcontractors to whom the Plan Sponsor supplies Electronic Protected Health information agree to implement reasonable and appropriate security measures to protect such information. The Plan Sponsor shall report any Security Incident (as defined in the applicable HIPAA regulations) of which it becomes aware to the applicable Plan.

Claims and appeals

To receive benefits from most of the Citi benefit plans, you will need to file a claim.

Medical	
▪ For all plans other than HMOs	Use one of the following forms available on Citi.net to file a claim for a covered out-of-network expense: ▪ 301 — Aetna Claim Form (for ChoicePlans 100 & 500, HDHP Basic & Premier participants). ▪ 303 — UnitedHealthcare Claim Form (for Hawaii Plan participants) ▪ 322 — BlueCross BlueShield (for ChoicePlans 100 & 500 participants). ▪ Based on your business group you may obtain forms via the Web www.Citi .net/human_resources/form.htm or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938. ▪ 310 — Express Scripts Retail Pharmacy–prescription drug program related to all non-HMO plans ▪ 311 — Express Scripts Home Delivery–prescription drug program related to all non-HMO plans
▪ HMO participants	▪ Call your HMO for any claim-filing information.
Dental	
▪ MetLife Preferred Dentist Program (PDP)	▪ Use Form 304 — MetLife Dental Claim form available on www.Citi.net. ▪ Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
▪ CIGNA Dental Care DHMO	▪ There are no claim forms to file under this plan.
▪ Delta Dental	▪ Use Form 307 — Delta Dental of New York Claim form available on Citi.net to file an out-of-network expense.
Vision	▪ Call Davis Vision at 1-800-999-5431 or visit www.davisvision.com.
Employee Assistance Program	▪ Call Harris Rothenberg at 1-800-952-1245 or visit www.harrisrothenberg.com (Benefit Service Claims Only)
General Purpose Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	▪ If you do not use your Citi FlexDirect debit card, you can file a claim by using the HCSA/LPSA Reimbursement Request Form. However, you may be asked to complete and return the Spending Account Substantiation Form 318 if ADP cannot substantiate a transaction applied to your Citi Flex Direct debit card. ▪ Based on your business group you may obtain forms via the Web www.Citi .net/human_resources/form.htm or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.

All claims for benefits must be filed within certain time limits.

- Medical, dental, and vision care claims must be filed within two years of the date of service.

- Prescription drug claims must be filed within one year of the date of service.
- HCSA/LPSA claims must be filed by June 30 of the calendar year following the plan year in which the expense was incurred.

To file a claim or appeal, you must use the designated form in accordance with Plan procedures. By participating in the Plans, you and your beneficiaries agree that you cannot commence a legal action against the Plans more than one year after your final appeal has been denied, unless an insurance contract made available under the Plan provides for a different limitation. No legal action can be brought to recover benefits under any of the Plans until the appeal rights described below have been exercised, and the Plan benefits requested in such appeal have been denied.

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*
Pre-service 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 pre-service 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 Claim Administrator.

The Customer Service telephone number is shown 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 Claim 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 identification 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 Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 Claim 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 pre-service claims, the first level appeal will be conducted and you will be notified by the Claim 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 Claim 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 Claim Administrator, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted to the Claim Administrator within 60 days from receipt of first level appeal decision.

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

For pre-service and post-service claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Claim Administrator as soon as possible. The Claim 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 Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim 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*
Pre-service 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.

Claim forms may be obtained at www.Citi.net. 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.

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 pre-service 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 Claim 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 Claim Administrator.

For pre-service and post-service claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 identification 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 Claim 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 Claim 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; or file a complaint of appeal with the Department of Insurance; or establish any litigation; or 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 independent physician, with appropriate expertise in the area at issue, of claim denials based upon 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 of this document 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 upon 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.

In order 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 pre-certification approval (called a “pre-certification 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
  - 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 appeal is received	Within 30 calendar days after appeal is received
You can make a second appeal to Empire BlueCross BlueShield, in writing	N/A	Within 60 calendar days after appeal denial is received	Within 60 calendar days after appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 calendar days after appeal is received	Within 30 calendar days after 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 pre-certification 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 that 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
- 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 pre-certification 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*
Pre-service 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 pre-service 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 Claim Administrator.

The Customer Service telephone number is shown 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 Claim 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 identification 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 Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 Claim 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 pre-service claims, the first level appeal will be conducted and you will be notified by the Claim 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 Claim 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 Claim Administrator, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted to the Claim Administrator within 60 days from receipt of first level appeal decision.

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

For pre-service and post-service claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Claim Administrator as soon as possible. The Claim 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 Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for Express Scripts (the non-HMO/EPO prescription drug program)

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 Claim 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*
Pre-service 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 Claim Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claim 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 Claim Administrator in considering the claim; and that demonstrates the Claim 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 Claim 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 pre-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claim 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 Claim Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claim 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 Claim Administrator, you have the right to request a second level appeal from the Claim Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claim Administrator within 60 days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, Citi has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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 Claim Administrator as soon as possible. The Claim 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 Claim Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for MetLife PDP

The amount of time MetLife 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*
Pre-service 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 have the right to request a reconsideration of the denied claim by calling or writing MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If after the review it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If after the review it is determined that the original denial stands, a denial letter is written.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- Explanation of why the charges are denied in plain language
- Reference to the plan (booklet) wording which justifies the denial

The appeal request must be submitted in writing to MetLife within 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

For pre-service and post-service claim appeals, Citi has delegated to MetLife as Claim Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim 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.

Claims and appeals for the CIGNA Dental Care DHMO

If you have a concern about your Dental Office or the CIGNA Dental Plan, you can call 1.800.CIGNA24 toll-free and explain your concern to a Member Services Representative. You can also express that concern to CIGNA Dental in writing. Most matters can be resolved with the initial phone call. If more time is needed to review or investigate your concern, CIGNA Dental will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

CIGNA Dental has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request in writing to the CIGNA Dental Plan within one year from the date of the initial CIGNA Dental decision. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your appeal by calling 1.800.CIGNA24.

CIGNA Dental level one appeal

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

If your appeal concerns a denied pre-authorization, CIGNA Dental will respond with a decision 15 calendar days after your appeal is received. For appeals concerning all other coverage issues, CIGNA Dental will respond with a decision within 30 calendar days after your request is received. If we need more information to make your level-one appeal decision, we will notify you in writing to

request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

- For New Jersey residents, CIGNA Dental will respond in writing within 15 working days;
- For Colorado residents, CIGNA Dental will respond within 20 working days; and
- For Nebraska residents, CIGNA Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a level two appeal.

CIGNA Dental level two appeal

To initiate a level-two appeal, follow the same process required for a level-one appeal. Your level-two appeal will be reviewed and a decision made by someone not involved in the level-one appeal. For appeals involving dental necessity or clinical appropriateness, the decision will be made by a dentist. If specialty care is in dispute, the appeal will be conducted by a dentist in the same or similar specialty as the care under review. The Level-Two Appeals process does not apply to resolutions made solely on the basis that the Dental Plan does not provide benefits for the service performed or requested.

The review will be completed within 30 calendar days. If we need more information to complete the appeal, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. The decision will include the specific contractual or clinical reasons for the decision, as applicable.

CIGNA Dental expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the plan will respond orally with a decision within 72 hours, followed up in writing.

- For Maryland residents, CIGNA Dental will respond within 24 hours; and
- For Texas residents, CIGNA Dental will respond within one business day.

CIGNA Dental independent review

The independent review procedure is a voluntary program arranged by the Dental Plan and is not available in all areas. Contact CIGNA Dental at 1.800.CIGNA24 for more details.

Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

CIGNA Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Claims and appeals for Delta Dental

The amount of time Delta Dental 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.*
Pre-service claims (for services requiring precertification of services)	Not applicable. Delta Dental does not condition the receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care.
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Usually not applicable. Urgent care claims do not ordinarily arise in the context of a fee-for-service plan involving dental care, such as Citi's dental plan. However, Delta Dental will comply with Department of Labor requirements for urgent care claims if any arise.
Concurrent care claims (for ongoing treatment)	Not applicable. Concurrent care claims do not occur in the context of a fee-for-service dental plan.

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

If a claim is denied in whole or in part, the claimant will receive a notice of payment or action that outlines the specific reason(s) and the specific plan provision(s) on which the determination was based. Upon request and free of charge, Delta Dental will provide the claimant a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying the claim.

If the claimant or his/her attending dentist wants the denial of benefits reviewed, the claimant or his/her attending dentist must write to Delta Dental **within one hundred eighty (180) days of the date on the Notice of Payment or Action. Failure to comply with such requirements may lead to forfeiture of the claimant's right to challenge the denial, even when a request for clarification has been made.**

The claimant's letter should state why the claim should not have been denied. Also, any other documents, data, information or comments that are thought to have bearing on the claim including the denial notice, should accompany the request for review.

The claimant or his/her attending dentist is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether the information was submitted or considered initially.

The review will be conducted for Delta Dental by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of the individual. If the review of a claim denial is based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta Dental will consult with a dentist

who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta Dental dental consultant who made the claim denial nor the subordinate of the dental consultant. The identity of the dental consultant will be available upon request whether or not the advice was relied upon. In making the review, Delta Dental will not afford deference to the initial adverse benefit determination.

If after review, Delta Dental continues to deny the claim, Delta Dental will notify the claimant or his/her attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta Dental will send the claimant or his/her attending dentist a notice, similar to this notice. If in the opinion of the claimant or his/her attending dentist, the matter warrants further consideration, the claimant should advise Delta Dental in writing as soon as possible.

The matter will be immediately referred to Delta Dental's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta Dental's Dental Affairs Committee if requested by the claimant or his/her attending dentist.

The Dental Affairs Committee will render a decision within thirty (30) days of the claimant's request for further consideration. The decision of the Dental Affairs Committee will be final insofar as Delta Dental is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board or to the courts with an action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) or other civil action.

Claims and appeals for the Vision Benefit Plan

The amount of time Davis Vision 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*
Pre-service 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 will have 180 days following receipt of a claim denial to appeal the decision. You have the right to voice a grievance or complaint against Davis Vision at any time. Davis Vision will not retaliate or take any discriminatory action against you because you have filed a grievance, complaint or appeal. A grievance is a complaint that may or may not require specific corrective action and is made:

- Via the telephone;
- In writing to Davis Vision; or
- Via the Davis Vision Web site.

Claims include but are not limited to the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;

- Difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, "adverse determination."

You may file a grievance by

- contacting Davis Vision's toll free hot line 24 hours a day at 1 800 584 1487;
- sending a letter via U.S. mail or overnight delivery; or
- logging on to the Web site: www.davisvision.com.

Written grievances should be sent to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attention: Quality Assurance/Patient Advocate Department

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

You will be contacted by a Davis Vision associate within five business days of receipt of a concern or grievance to confirm that the concern was received and is being investigated. A designated Davis Vision associate will review the appeal with you and may request additional information. You will be provided with the Associate's name, phone number, department and the estimated time needed to perform the research (for pre-service appeals, 15 days; for post-service appeals, 30 days) and when you can expect a determination. You will also be informed of your right to have a representative, including your provider, present during the review of the concern and final outcome of the investigation. You also will be informed of your right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions, the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point-of-service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. When further information is required, Davis Vision will contact you and inform you of the status of the investigation and/or the need for more information.

At the conclusion of the investigation, the determination will be communicated within 15 days for pre-service claims and 30 days for post-service claims, or as required by state statute, (or an additional 10 days may be requested in order to complete further research). The appeal determination will include the following:

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including the documentation supporting the decision;

- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;
- Copy of the appeals process, if applicable; and
- Name, position, phone number and department of the person(s) who was responsible for the outcome.

The decision of the Quality Assurance/Patient Advocate Department is final and binding unless you appeal to Davis Vision within 15 business days of the date of notice of the decision.

Davis Vision level two appeal

Should Davis Vision uphold a denial, as the result of a level one review, you have the right to request a level two appeal.

A level two appeal will not include any associate(s) or licensed (peer) health care professional(s) that were involved in the level one review.

A level two appeal requires you to contact Davis Vision in writing or by telephone within 15 days following your receipt of the level one summary statement.

If you are requesting a level two appeal, you must indicate the reason you believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to solicit further information from you and/or the provider.

Davis Vision has 30 days, or as required by state statue, from the date the requested information is received, to respond to the level two review, or 45 days, or as required by state statute, if it is a post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within 5 days.

Notification will include, but may not be limited to:

- The outcome of the investigation and a summary stating the nature of the concern and the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including documentation that was used to support the decision;
- A statement indicating that the decision will be final and binding unless you appeal in writing or by telephone to the Quality Assurance/Patient Advocacy Department within 45 days of the date of the notice of the level two decision;
- A copy of the appeals process, if applicable; and
- The name, position, phone number and department of person(s) who was responsible for the outcome.

External review

Davis Vision gives you, as required by state statute, an opportunity to request an impartial review of concerns that resulted in coverage denials. If you have utilized and exhausted the internal appeals

process, you may appeal the final decision if the denial for services exceeds $250 and was not deemed medically necessary or the requested service was deemed investigational or experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organization will have up to 30 days, or as required by state statute, to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that each state has implemented an external review process that is unique to their residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. You can call the Member Service Department at 1 800 999 5431 for information unique to your state of residence. You also have the right to contact your state insurance or health department for further information.

You have the right to an external review of a denial of coverage. You have the right to an external review of a final adverse decision under the following circumstances:

- You have been denied a vision care service, which should have been covered under the terms of the vision care plan;
- Services were denied on appeal on the basis that requested services were not medically necessary;
- A treatment or service that will have a significant positive impact on you has been denied and any alternative service or treatment will not affect your ocular health and/or will produce a negative outcome;
- The services denied are related to a current illness or injury;
- The cost of the requested services will not exceed that of any equally effective treatment;
- The denied service, procedure, or treatment is a covered benefit under the vision care plan; or
- You have exhausted all internal appeal processes with an adverse determination upheld at each level.

The vision care provider may contact the appropriate state agency to determine if other documentation may be required for the appeal process.

The external review representative must make a decision within 30 days of receipt of documentation, or as required by state statute, and notifies you within two business days of a determination. Notification must be in writing and include an explanation and the clinical criteria utilized in the decision.

Claims and appeals for the HCSA/LPSA

If you are denied a benefit under the HCSA/LPSA, you should proceed in accordance with the following procedures.

Step 1: Denial Notice is received from ADP. If your claim is denied, you will receive written notice from ADP that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of ADP, ADP may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide

additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which ADP must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Review your notice carefully. Once you have received your notice from ADP, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures;
- a right to request all documentation relevant to your claim; and
- a statement explaining your rights to bring civil action under Section 502(a) of ERISA after an adverse benefit determination upon review.

Step 3: If you disagree with the decision, file an appeal. If you do not agree with ADP's decision, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. You should file your appeal with ADP at the address provided below. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

ADP Claim Appeals
P.O. Box 1801
Alpharetta, GA 30023-1801

Step 4: Notice of Denial is received from claims reviewer. If the claim is again denied, you will be notified in writing. The notice will be sent no later than 30 days after receipt of the appeal by ADP.

Step 5: Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third party administrator.

Step 6: If you still disagree with ADP's decision, file an appeal with Citi. If you still do not agree with the ADP's decision, you may file a written appeal with Citi at the address listed below within 60 days after receiving the latest denial notice from ADP. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If Citi denies your Appeal, you will receive notice within 30 days after the Citi receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Citigroup Inc.
Plans Administration Committee of Citigroup Inc.
125 Broad Street, 8th Floor
New York, NY 10004

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Claim Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plans. Notwithstanding any provision of the Plan to the contrary, you must file any lawsuit with respect to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination, or if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan, that period will apply to suits against the insurer.

Wellness programs

Effective in 2007, The Plan Sponsor adopted several broad-based administrative programs intended to improve the health of Plan participants and reduce Plan Sponsor costs. These programs known together as Citi Live Well, are an element of your participation in the Plans. For details on the programs, see the 2009 Health and Welfare Summary Plan Description.

Administrative information

This section contains general information about the administration of the Citi Plans, the plan documents, sponsors, and Claim Administrators. In addition, a statement about the future of the plans and Citi's right to amend, modify, suspend, or terminate is outlined in this section.

Future of the plans and plan amendments

Citi has the right to amend, modify, suspend, or terminate any Plan, in whole or in part, at any time for any reason without prior notice. Citi may make any such amendment, modification, suspension, or termination of the plans for any reason. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other

documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements. The Plans are subject to various legal requirements, which may require changes in the Plans.

In the event of the dissolution, merger, consolidation or reorganization of Citi, the Plans will terminate unless the Plans are continued by a successor to Citi.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citi to the extent permitted under applicable law.

No right to employment

Nothing in this document represents or is considered an employment contract, and neither the existence of the Plans nor any statements made by or on behalf of Citi shall be construed to create any promise or contractual right to employment or to the benefits of employment. Citi or you may terminate the employment relationship without notice at any time and for any reason.

Plan administration

The Plan Administrator, the Plans Administrative Committee of Citigroup Inc., is responsible for the general administration of the Plans, and is the "named fiduciary" under ERISA for each of the Plans. The Plan Administrator will be the Plan fiduciary to the extent not delegated to a Claim Administrator pursuant to an agreement or other document or arrangement. The Plan Administrator and, where delegated, the Claim Administrators have the exclusive discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plans, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The Plan Administrator has designated other organizations or persons to act out specific fiduciary responsibilities in administering the plan including, but not limited to, any or all of the following responsibilities:

- To administer and manage the Plans including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plans; and
- To act as Claim Administrator and to review claims and claim denials under the Plans to the extent another insurer or administrator is not empowered with such responsibility.

The delegation by the Plan Administrator may (but is not required to) be in writing. Except to the extent superseded by laws of the United States, the laws of New York will be controlling in all matters relating to the Plans.

Funding and payment policy

Benefits under the Health Benefit Plan and the Dental Benefit Plan may be funded from the general assets of Citi, a trust qualified under section 501(c)(9) of the Internal Revenue Code, or under insurance contracts. The Vision Benefit Plan is fully insured, and the Health Care Spending Account is funded from general assets of Citi. The costs of the Health Benefit Plan, the Dental Benefit Plan, and the Vision Benefit Plan are shared between Citi and the plan participants. The cost of the Health Care Spending Account is generally borne by the participants. The cost of the Citi Employee Assistance Program is borne by Citi. Any refund, rebate, dividend adjustment or other similar payment under any insurance contract entered into between Citi and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citi for premiums it has paid or to reduce Plan expenses. All Plan assets shall be used to pay benefits under the Plans or pay the reasonable expenses of Plan administration. Payments under the Plans shall be made in accordance with Plan terms, insurance policies, or administrative agreements.

Compliance with law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA, HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, and the Women's Health and Cancer Rights Act of 1998.

Compliance with Section 125 of the Internal Revenue Code

About Your Health Care Benefits, the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan, and the Citigroup General Purpose Health Care Spending Account, and the Limited Purpose Health Care Spending Account and documents governing participant elections generally are, when read together, intended to comply with the requirements of Section 125 of the Internal Revenue Code of 1986, as amended, and constitute a cafeteria plan. All such documents are incorporated by reference to constitute a single plan, in accordance with applicable Treasury regulations.

As stated previously in this document, all participants are entitled to make their benefit elections under the foregoing Plans through salary reduction arrangements so that the participant's premium payments or health care spending account contributions can be made on a pre-tax basis. While the above-mentioned benefit Plans describe the benefits available, this About Your Health Care Benefits document authorizes employees to enter into salary reduction arrangements to pay their portion of the health care premiums on a pre-tax basis and authorizes employees to defer amounts under the health care spending accounts on a pre-tax basis with respect to subsequent expenses that will be incurred and later reimbursed. Changes in such elections are available only in limited circumstances set forth in the Plan document. The change in coverage must be consistent with the change in status. For example, if a dependent is added, the coverage should increase (not decrease). In addition to the foregoing, the Plans permit election changes based on the special enrollment rights under HIPAA.

Plan information

Employer Identification Number	52-1568099
Participating Employers	Citigroup Inc. and any of its [U.S.] subsidiaries in which at least an 80% interest is owned.
Plan Names and Numbers	
▪ Medical plans (self-funded ChoicePlans, High Deductible Health Plans (Basic and Premier), Hawaii Health Plan, and HMOs) including prescription drugs	Citi Health Benefit Plan Plan number 508
▪ Dental plans	Citi Dental Benefit Plan Plan number 505
▪ Vision care plan	Citi Vision Benefit Plan Plan number 533
▪ General Purpose Health Care Spending Account/Limited Purpose Health Care Spending Account	Citi Flexible Benefits Plan Plan number 512
▪ Employee Assistance Program	Citi Employee Assistance Program Plan number 521
Plan Administrator	Plans Administration Committee of Citigroup Inc. 125 Broad Street, 8th Floor New York, NY 10004
Plan Sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
Claim Administrators Each of the Claim Administrators has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of the Plans— namely, those provisions of the Plan document that apply to the participant and administered by that particular Claim Administrator.	
ChoicePlans and High Deductible Health Plans (Basic and Premier)	Aetna Citi Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
For fully insured HMOs	Call the Citi HMO Administrator at 1-800-422-6106
Oxford Health Plans PPO	Oxford Health Plans Attn: Claims Department P.O. Box 7082 Bridgeport, CT 06601-7082 1-800-760-4566

Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
For Prescription Drug Program	
▪ Retail Pharmacy	Express Scripts Health Prescription Solutions, Inc. P.O. Box 2187 Lee's Summit, MO 64063-2187
▪ Express Scripts By Mail	Express Scripts, Inc. Home Delivery Services P.O. Box 510 Bensalem, PA 19020-0510
For Dental Plans	
▪ MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Company MetLife Dental Claims Unit P.O. Box 981282 El Paso, TX 79998-1282 1-888-832-2576 1-859-389-6505 Fax To submit an Appeal: Metropolitan Life Insurance Company P.O. Box 14093 Lexington, KY 40512-4093
▪ CIGNA Dental Care DHMO	CIGNA Dental P.O. Box 189060 Plantation, FL 33318 1.800.CIGNA24
▪ Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783
For Vision Benefit Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
For Health Care Spending Account, Limited Purpose Health Care Spending Account, and Dependent Care Spending Account	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693
Agent for Service of Legal Process	Citigroup Inc. General Counsel 399 Park Avenue, 3rd Floor New York, NY 10043

Plan Year (for all Plans)	January 1 — December 31
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators.

Notice required by the Florida Insurance Department: Some of these plans are self-insured group health plans not regulated by the Florida Insurance Department. Payment of claims is completely dependent upon the financial solvency of the employer or other entity sponsoring the plans. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or plan sponsor cannot pay.

Citi Health Benefit Plan

Amended and Restated as of January 1, 2009

Citi Health Benefit Plan

This plan document sets forth the terms and conditions of your benefits under the Citi Health Benefit Plan (the "Plan"), as amended and restated as of January 1, 2009. Citi has entered into arrangements with Aetna, Empire BlueCross BlueShield, Oxford PPO Health Plans, and Hawaii Health Plan which provide for the Plan to process medical benefit claims and provide certain other services. Aetna, Empire BlueCross BlueShield, Oxford PPO Health Plans, do not insure the benefits described in this Plan document. This document should be read in combination with the *About Your Health Care Benefits* document, amended and restated as of January 1, 2009, which is also a component of the Plan document.

The Plan offers several medical options to protect you and your eligible dependents against the high cost of treating major illness and injury. Depending on your location, you may choose from:

- ChoicePlan 100 Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield ("PPO" Preferred Provider Organization plan);
- 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, NY, NJ only) or
- Hawaii Health Plan (UnitedHealthcare, available in Hawaii only).

Citi reserves the right to change or discontinue any or all of the benefits coverage or programs described here at any time, with or without notice.

The benefits and programs described in this document are, in effect as of January 1, 2009. The terms and conditions of these plans may also be further prescribed in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

This document is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citi and any individual. Your employment is always on an at-will basis. In addition, benefits provided under the plans described in this document are not in any way subject to your or your dependent's debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

As you read the document you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document (or in the *About Your Health Care Benefits* document).

In addition, Citi in no way guarantees the payment of any benefit which may be or become due to any person under any plan.

If you have any questions about this document or certain provisions of your benefit plans, or would like to receive copies of an insurance policy or other document forming a part of the Plan, please call the Benefit Service Center at ConnectOne at 1-800-881-3938 and select the Health Benefits options.

Citi Health Benefit Plan

ChoicePlans

Under a ChoicePlan, you have the freedom to choose your doctor or healthcare facility when you need healthcare. 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.

- Citi offers two ChoicePlans: ChoicePlan 100 and ChoicePlan 500, administered by Aetna and Empire BlueCross BlueShield. When you enroll in the ChoicePlan, you may request a provider directory that lists doctors and other providers who belong to the network by calling the Claim Administrator or by visiting the Claim Administrators' web sites.
  - Aetna's Web site — www.aetna.com, select the Aetna Open Access, Choice POSII Open Access Plan or call 800-545-5862
  - Empire BlueCross BlueShield's Web site — 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)", and then "PPO/EPO" option from drop down list. Or you may call 866-290-9098

ChoicePlan 100

Type of service	Network	Out-of-network
Annual deductible		
▪ Individual	▪ $100	▪ $500
▪ Maximum per family	▪ $200	▪ $1,000
Annual out-of-pocket maximum (includes deductible)		
▪ Individual	▪ $2,000	▪ $4,000
▪ Maximum per family	▪ $4,000	▪ $8,000
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

Type of service	Network	Out-of-network
Preventive care (subject to frequency limits)		
▪ Well adult (including both travel and non-travel related immunizations)	▪ 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
▪ Well child (including both travel and non-travel related immunizations)		
▪ Cancer Screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy and PSA screening)		
▪ The $250 annual credit per person applies to out of network wellness services		
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, 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		
▪ Semi-private room and board, doctor's charges, lab, x-ray, and surgical care	▪ 90% after deductible; prenotification is required for hospitalization and certain outpatient procedures	▪ 70% of R&C after deductible; prenotification 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 ▪ Pre-notification recommended 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 - 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)	▪ $50 copayment, waived if admitted for any reason within 24 hours	▪ $50 copayment, waived if admitted for any reason within 24 hours
▪ Urgent care facility	▪ 90% after deductible	▪ 90% of R&C after deductible; 70% of R&C after deductible for Empire BlueCross BlueShield participants

Type of service	Network	Out-of-network
Non-routine outpatient lab and x-ray services	▪ 90% after deductible	▪ 70% of R&C after deductible
Outpatient short-term rehabilitation		
▪ Physical, speech, or occupational therapy All therapy visits are reviewed for medical necessity. PT/ST/OT therapies are combined and will be paid out at the following level if deemed medically necessary: up to a maximum of 60 approved visits paid 90% in network and 70% out of network. Additional visits over the maximum are reviewed on a case by case basis for medical necessity and paid out at a lesser rate (70% in-network and 50% out-of-network.)	▪ 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; notification recommended	▪ 70% of R&C after deductible, limited to 200 visits annually for network and out-of-network services combined; notification required
Hospice	▪ 90% after deductible; notification recommended	▪ 70% of R&C after deductible; notification required
Skilled nursing facility	▪ 90% after deductible (limited to 120 days annually for network and out-of-network services combined); notification required	▪ 70% of R&C after deductible (limited to 120 days annually for network and out-of-network services combined); notification required

Type of service	Network	Out-of-network
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. ▪ 90% after deductible up to the family lifetime maximum-in network ▪ 70% of R&C after deductible up to the family lifetime maximum-out of network	
	▪ Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum	
	▪ Contact the Claim Administrator for specific coverage.	
Prescription drugs (refer to "Prescription drug program" on page 67)		
Mental health and chemical dependency (refer to ""Out-of-network coverage" on page 20)		

ChoicePlan 500

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

Type of service	Network	Out-of-network
Preventive care (subject to frequency limits)		
▪ Well adult (including both travel and non-travel related immunizations) ▪ Well child (including both travel and non-travel related immunizations) ▪ Cancer Screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy and 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, 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		
▪ Semi-private room and board, doctor's charges, lab, x-ray, and surgical care	▪ 90% after deductible; notification 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 ▪ Pre-notification recommended 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)	▪ $50 copayment, waived if admitted for any reason within 24 hours	▪ $50 copayment, waived if admitted for any reason within 24 hours
▪ Urgent care facility	▪ 90% after deductible	▪ 90% of R&C after deductible; 70% of R&C after deductible for Empire BlueCross BlueShield participants

Type of service	Network	Out-of-network
Non-routine outpatient lab and x-ray services	▪ 90% after deductible	▪ 70% of R&C after deductible
Outpatient short-term rehabilitation		
▪ Physical, speech, or occupational therapy All therapy visits are reviewed for medical necessity. PT/ST/OT therapies are combined and will be paid out at the following level if deemed medically necessary: up to a maximum of 60 approved visits paid 90% in network and 70% out of network. Additional visits over the maximum are reviewed on a case by case basis for medical necessity and paid out at a lesser rate (70% in network and 50% out of network.)	▪ 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; notification recommended	▪ 70% of R&C after deductible, limited to 200 visits annually for network and out-of-network services combined; notification required
Hospice	▪ 90% after deductible; notification recommended	▪ 70% of R&C after deductible; notification required
Skilled nursing facility	▪ 90% after deductible (limited to 120 days annually for network and out-of-network services combined); notification required	▪ 70% of R&C after deductible (limited to 120 days annually for network and out-of-network services combined); notification required

Type of service	Network	Out-of-network
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. ▪ 90% after deductible up to the family lifetime maximum-in network ▪ 70% of R&C after deductible up to the family lifetime maximum-out of network	
	▪ Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum	
	▪ Contact the Claim Administrator for specific coverage.	
Prescription drugs (refer to "Prescription drug program" on page 67)		
Mental health and chemical dependency (refer to ""Out-of-network coverage" on page 20)		

These charts 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 84 and "Exclusions and limitations" on page 101.

Network coverage

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

Deductible

If you elect to use physicians or other providers in the network, you will need to satisfy an annual deductible ($100 individual/$200 family; $500/$1,000) before any benefit will be paid. Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-network.

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 $100/$500 individual deductible; or
- Three or more in a family: Expenses can be combined to meet the $200/$1,000 family deductible, but no one person can apply more than the individual deductible ($100/$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 are $2,000 individual/$4,000 family (Choice Plan 100); $3,000/$6,000 (Choice Plan 500). 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 any expenses incurred for mental health/chemical dependency services, or services not covered under the ChoicePlans. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claim 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 ($2,000/$3,000) to the family out-of-pocket maximums ($4,000/$6,000).

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

- Pharmacy expenses;
- Any charges for mental health/chemical dependency services (these charges do however count toward the deductible); and
- Charges for services not covered under the ChoicePlans.

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)

It is important when seeking primary care services to choose a provider from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in the ChoicePlans are available directly from the Claim Administrator. You may call or visit the Claim Administrator's Web site:

- Aetna's Web site — www.aetna.com, select the Aetna Open Access, Choice POSII Open Access Plan or call 800-545-5862
- Empire BlueCross BlueShield's Web site — 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)", and then "PPO/EPO" option from drop down list. Or you may call 866-290-9098. Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-network.

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 expenses that are received in-network.

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, CT, DE, FL, GA, NJ, NY, OH, and TX

When you visit an Aexcel specialist the Plan will pay 95% of covered expenses and you do not need referrals for Aexcel specialists. To find Aexcel specialists 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 and you are charged for an office visit, 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 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 ChoicePlans offer additional coverage for routine care services to help detect health problems early. .

- 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.

Infertility

The ChoicePlans cover 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 family lifetime maximum.

These coverage limits include infertility treatment in-network and out-of-network and across all non-HMO/PPO plans combined. Coverage for prescription drugs used to treat infertility is provided through the Prescription drug program. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

For more specific information, contact the Claim Administrator.

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.

See the “Glossary” on page 107 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 the Claim Administrator within 48 hours. If you are unable to do this,

have a family member contact the Claim Administrator. Non-emergency services provided in the emergency room are not covered by the ChoicePlans.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a provider is not available. The centers usually have evening and weekend hours and generally 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on the Claim Administrators' web sites. 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 Claim Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claim 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 the ChoicePlan or not approved by the ChoicePlan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the ChoicePlan and are not payable by the Claim Administrator.

For information about how to file a claim or appeal a denied claim, see the "Claims and appeals**"** section in the *About Your Health Care Benefits* document.

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under the ChoicePlans. 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**"** section in the *About Your Health Care Benefits* document.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible ($500 individual/$1,000 family –Choice Plan 100; $1,500/$3,000 –Choice Plan 500) 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/$1,500 individual deductible; or
- Three or more in a family: Expenses can be combined to meet the $1,000/$3,000 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, the ChoicePlan 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 $4,000 individual/ $8,000 family; $6,000/$12,000. This amount includes the ($500/$1,500 individual and $1,000/$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, any coinsurance charges for mental health/chemical dependency services, or services not covered under the ChoicePlans. 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 ($4,000/$6,000) to the family out-of-pocket maximum ($8,000/$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;
- Any coinsurance charges for mental health/chemical dependency services; 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

Preventive care services are available in the ChoicePlans.

Each participant has a $250 annual credit toward all wellness services out of network. Thereafter, covered expenses are not subject to the deductible and 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 immunizations and well-child immunizations performed by non-network providers. Well 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:

- 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.

Infertility

The ChoicePlans cover 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 family lifetime maximum.

These coverage limits include infertility treatment in-network and out-of-network and across all non HMO/PPO plans combined. Coverage for prescription drugs used to treat infertility is provided through the Prescription drug program. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

For more specific information, contact the Claim Administrator.

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. If you are admitted to the hospital for any condition, the copayment is waived.

See the “Glossary” on page 107 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 the Plan Administrator within 48 hours. If you are unable to do this, have a family member contact the Claim Administrator.

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

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and generally 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on the Claim Administrators’ web sites. 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. 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

The ChoicePlans provide confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call the Claim 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 Claim Administrator before seeking treatment for mental health or chemical dependency treatment.

Action	Inpatient*	Outpatient
If you call the Plan and use its network provider/facility All visits even up to the max benefits are reviewed for medical necessity; the max limit is not a guarantee.	Eligible expenses covered at 90% after deductible of the negotiated rate; maximum benefit of 30 days per calendar year. Eligible expenses covered at 70% after deductible for - days approved for medical necessity over plan limit.**	90% after deductible; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 70% after deductible for visits approved for medical necessity over plan limit.**

Action	Inpatient*	Outpatient
If you call the Plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year. Eligible expenses covered at 50% of R&C after deductible for days approved for medical necessity over plan limit.**	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 50% of R&C after deductible for visits approved for medical necessity over plan limit.**

* Inpatient pre-notification is recommended.

** Maximum benefits are combined for network and out-of-network services.

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 the ChoicePlans. Your coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under the ChoicePlans.

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. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

The ChoicePlans pay benefits at the network level (90% of negotiated rate contracted with the Claim 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. There is a maximum benefit of 30 days per calendar year for inpatient mental health/chemical dependency

services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services and covered at 50% of R&C after deductible for out-of network services. Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by the ChoicePlan in advance of the admission.

Outpatient services

You are encouraged to call the Claim 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 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity. Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services and covered at 50% of R&C after deductible for out-of network services.

Emergency care

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

Medically necessary

The Claim Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claim 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 Claim Administrator determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" on page 107 for a definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 84. 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 ChoicePlans 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 pre-certification or concurrent review. The discharge plan may include initiation of a

variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Aetna High Deductible Health Plans – Basic

Type of service	Network	Out of Network
Citi funded HSA $500 (single)/$1,000 (family)		
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;	▪ 70% of R&C after deductible
Preventive care (subject to frequency limits)		
▪ Well adult (including both travel and non-travel related immunizations)	▪ 100% no deductible	▪ 100% of R&C, no deductible
▪ Well child (including both travel and non-travel related immunizations)		
▪ Cancer Screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy and PSA screening)		
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; notification required for hospitalization, facility admissions and certain outpatient procedures and services	▪ 70% of R&C after deductible; notification required for hospitalization, facility admissions and certain outpatient procedures and services

Type of service	Network	Out of Network
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 true emergency)		
▪ Hospital emergency room ▪ (includes emergency room facility and professional services provided in the emergency room)	▪ 80% of covered services after deductible	▪ 80% of covered services after deductible
▪ Urgent care facility	▪ 80% of covered services after deductible	▪ 70% 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 drug program" on page 67)		
Mental health and chemical dependency (refer to ""Mental health/chemical dependency" on page 31)		

This chart 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 84 and "Exclusions and limitations" on page 101.

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 in-network providers or out-of-network providers. Using in-network providers saves you money in two ways. First, in-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 an in-network provider.

A directory of in-network providers is available directly from the Claim Administrator.

- Aetna's Web site — www.aetna.com, select the Aetna Open Access, Choice POSII Open Access Plan or call 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 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.

Only covered expenses that count toward the deductible count toward the individual or family deductible. There is no individual within the family deductible limit. One family member or a combination of family members must meet the full family deductible before the plan pays any benefits. 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 an in-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 (non-network -$7,500-individual/$15,000 family). The amount includes the $2,100 individual/ $4,200 family (non-network $3,100/$6,200) 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 ($5,000/7,500 non-network) to the family out-of-pocket maximum ($10,000/15,000 non-network).

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, pharmacy copayments, any coinsurance charges for mental health/chemical dependency services, 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

Preventive care services are available in the Aetna HDHP Basic.

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
- **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."

Infertility

HDHP Basic covers medical and pharmacy expenses associated with infertility treatment, subject to the following limits:

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

Note: Coverage for prescription drugs used to treat infertility is provided through the Prescription drug program. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all non-HMO plans combined.

For more specific information, contact the Claim Administrator directly.

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.

See the “Glossary” on page 107 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 the Claim Administrator within 48 hours. If you are not able to do this, have a family member contact the Claim Administrator.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). 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.

For more information about how to file a claim or appeal a denied claim, see "Claims and appeals for Aetna medical plans**"** in the *About Your Health Care Benefits* document.

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 Claim 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	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; maximum of 30 days per calendar year. Eligible expenses covered at 70% after deductible for days approved for medical necessity over plan limit.**	After the deductible, eligible expenses covered at 80% of negotiated rate; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 70% after deductible for visits approved for medical necessity over plan limit.**
If you call the Plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year** Eligible expenses covered at 50% after deductible for days approved for medical necessity over plan limit	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year** Eligible expenses covered at 50% after deductible for days approved for medical necessity over plan limit

* Inpatient pre-notification is recommended.

** Maximum benefits are combined for network and out-of-network services.

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 Basic. Your coinsurance under the mental health and chemical dependency program may differ from those 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. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You *must* call the Claim 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. There is a maximum benefit of 30 days per calendar year for mental health/chemical dependency inpatient services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable. Eligible expenses will be covered at 70% of the negotiated rate after the deductible for approved visits over plan limit for in-network services and covered at 50% after the deductible for out-of network services.

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

Outpatient services

You are encouraged to call the Claim 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 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity. Eligible expenses will be covered at 70% after the deductible for approved visits over plan limit for in-network services and covered at 50% after the deductible for out-of network services.

Emergency care

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

Medically necessary

The Claim Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claim 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 Claim Administrator determines that the covered services and supplies are medically necessary. Please refer to the "Glossary" on page 107 for a definition of medical necessity.

For more information about what your Plan covers, see "Covered services and supplies" on page 84. 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
Citi funded HSA $500 (single)/$1,000(family) if you elected the HSA.		
Annual deductible (includes prescription drug expenses)		
▪ Single	▪ $1,200	▪ $2,400
▪ Family	▪ $2,400	▪ $4,800
Annual out-of-pocket maximum (includes deductible)		
▪ Single	▪ $2,500	▪ $5,000
▪ Family	▪ $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;	▪ 70% of R&C after deductible

Type of service	Network	Out of Network
Preventive care (subject to frequency limits)		
▪ Well adult (including both travel and non-travel related immunizations)	▪ 100%, no deductible	▪ 100% of R&C, no deductible
▪ Well child (including both travel and non-travel related immunizations)		
▪ Cancer Screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy and PSA screening)		
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; notification required for hospitalization, facility admissions and certain outpatient procedures and services	▪ 70% of R&C after deductible; notification required for hospitalization, facility admissions 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 true emergency)		
▪ Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	▪ 90% of covered services after deductible	▪ 90% of covered services after deductible
▪ Urgent care facility	▪ 90% of covered services after deductible	▪ 70% 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

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, 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 drug program" on page 67)		
Mental health and chemical dependency (refer to "Mental health/chemical dependency" on page 31)		

This chart 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 84 and "Exclusions and limitations" on page 101.

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 in-network providers or out-of-network providers. Using in-network providers saves you money in two ways. First, in-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 an in-network provider.

A directory of in-network providers is available directly from the Claim Administrator.

- Aetna's Web site — www.aetna.com, select the Aetna Open Access, Choice POSII Open Access Plan or call 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.

Only covered expenses that count toward the deductible count toward the individual or family deductible. There is no individual within the family deductible limit. One family member or a combination of family members must meet the full family deductible before the plan pays any benefits. 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.

Once you have satisfied the deductible, HDHP Premier normally pays 90% of the negotiated rate for covered health services if you or your covered dependent uses an in-network hospital/provider. Expenses are normally reimbursed at 70% of Reasonable and Customary for claims for covered services submitted for an out-of-network provider.

Out-of-pocket maximum

Your out-of-pocket maximum is $2,500 individual/$5,000 family.(non-network $5,000 individual/$10,000 family) The amount includes the $1,200 individual/$2,400 family(non-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 non-network) to the family out-of-pocket maximum ($5,000/10,000 non-network).

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, pharmacy copayments, any coinsurance charges for mental health/chemical dependency services, 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

Preventive care services are available in the Aetna HDHP Premier.

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."

Infertility

HDHP Premier covers medical *and* pharmacy expenses associated with infertility treatment, subject to the following limits:

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

Note: Coverage for prescription drugs used to treat infertility is provided through the Prescription drug program. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all non-HMO plans combined.

For more specific information, contact the Claim Administrator directly.

Hospital

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

- 90% for care received from an in-network provider; or
- 70% for care received from an out-of-network provider in an area where a network provider is available.

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:

- 90% for care received from an in-network provider and an out-of network provider.

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

See the "Glossary" on page 107 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 the Claim Administrator within 48 hours. If you are not able to do this, have a family member contact the Claim Administrator.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). Urgent care centers will be reimbursed at:

- 90% 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.

For more information about how to file a claim or appeal a denied claim, see "Claims and appeals for Aetna medical plans**"** in the *About Your Health Care Benefits* document.

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 Claim 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	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; maximum of 30 days per calendar year. Eligible expenses covered at 70% after deductible for days approved for medical necessity over plan limit.**	After the deductible, eligible expenses covered at 90% of negotiated rate; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 70% after deductible for visits approved for medical necessity over plan limit.**
If you call the Plan but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year** Eligible expenses covered at 50% after deductible for days approved for medical necessity over plan limit	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year** Eligible expenses covered at 50% after deductible for days approved for medical necessity over plan limit

* Inpatient pre-notification is recommended.

** Maximum benefits are combined for network and out-of-network services.

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. Your coinsurance under the mental health and chemical dependency program may differ from those 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. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You *must* call the Claim 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. There is a maximum benefit of 30 days per calendar year for mental health/chemical dependency inpatient services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable. Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services and covered at 50% after deductible for out-of network services.

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

Outpatient services

You are encouraged to call the Claim 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 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity. Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services and covered at 50% after deductible for out-of network services.

Emergency care

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

Medically necessary

The Claim Administrator will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The Claim 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 Claim Administrator determines that the covered services and supplies are medically necessary. Please refer to the “Glossary” on page 107 for a definition of medical necessity.

For more information about what your Plan covers, see “Covered services and supplies” on page 84. 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)

Health Savings Accounts (HSAs) and HDHPs

Two savings programs are available to help High Deductible Health Plan participants pay for eligible expenses: the Health Savings Account (HSA) and the Limited Purpose Health Care Spending Account (LPSA).

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

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

To enroll in an HSA, you must be covered by an HSA-compliant plan, such as the High Deductible Health Plan, and you cannot be enrolled in "impermissible medical care coverage," such as a Health Care Spending Account.

Health Savings Account

If you enroll in either the High Deductible Health Plan (Basic or Premier) and you establish an HSA at Citibank, N.A., Citigroup will contribute to your account. The contribution amounts are up to $500 for Employee Only coverage and up to $1,000 for any of the family coverage categories. "Establish" an account means you apply for an account and meet certain credit and "know your customer" requirements. If your account is not established, you cannot receive the employer contribution.

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

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.
- Qualified 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: HSAs, whether administered by Citibank or another administrator, are not part of the Citigroup Medical Plans or any other employee benefit plan sponsored by Citigroup.

Limited Purpose Savings Account

LPSA If you enroll in an HDHP and make tax-free contributions to an HSA you can no longer participate in the Health Care Spending Account (HCSA). HCSA enrollment disqualifies your contributions to the HSA.

According to Internal Revenue Service (IRS) regulations, if you enroll in a High Deductible Health Plan and an HSA you can enroll in a Limited Purpose Health Care Spending Account (LPSA) to reimburse yourself for eligible expenses such as those for vision, dental, and preventive medical care.

For more information, contact your tax adviser or visit the IRS Web site at www.irs.gov.

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 4 consecutive weeks. Full medical coverage will be continued for a disabled employee for three months following the month of disability

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 preferred providers; 80% of R&C after deductible when using non-preferred providers
Routine care (subject to frequency limits)	
▪ Well-adult (including both travel and non-travel related immunizations)	▪ 80%, no deductible
▪ Well-child and immunizations (including both travel and non-travel related immunizations)	▪ 80%, no deductible

Type of service	Hawaii Health Plan (UnitedHealthcare — available in Hawaii only)
Hospital inpatient and outpatient	
▪ Semiprivate room and board, doctor's charges, lab, x-ray, and surgical care	▪ Inpatient: 90% after deductible when using preferred physicians; 80% of R&C after deductible when using preferred hospital; 80% after deductible when using non-preferred physicians; 80% of R&C after $100 confinement deductible and calendar year deductible when using non-preferred hospitals ▪ Outpatient: 90% after deductible when using preferred physician; 80% of R&C after deductible when using non-preferred 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 preferred providers; 80% of R&C after deductible when using non-preferred providers
Prescription drugs (refer to "Prescription drug program" on page 67)	
Mental health and chemical dependency (refer to "Mental health/chemical dependency" on page 46	

This chart 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 84 and "Exclusions and limitations" on page 101.

How the Plan works

This section contains more detailed information about Hawaii Health Plan's provisions and how the medical plan option 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**"** in the *About Your Health Care Benefits* document.

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, any coinsurance charges for mental health and chemical dependency treatment, and penalties applied for failure to notify UnitedHealthcare.

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.

Infertility

The Hawaii Health plan covers medical *and* pharmacy expenses associated with infertility treatment, subject to the following limits:

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

Note: Coverage for prescription drugs used to treat infertility is provided through the Prescription drug program. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all non-HMO/PPO plans combined.

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.

Notification is required for hospitalization, facility admissions, and certain outpatient procedures and services. For more information, see "Precertification/notification" on page 76.

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" on page 107 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 76. 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).

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). Urgent care centers will be reimbursed at:

- 90% of the negotiated rate (after deductible) for care received by a UnitedHealthcare preferred provider; or
- 80% of R&C (after deductible) for claims submitted by a non-preferred provider.

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 76.

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 expenses covered at 80% of the negotiated rate; maximum of 30 days per calendar year. Eligible expenses covered at 70% after deductible for approved visits over plan limit.*	After the deductible, eligible expenses covered at 80% of R&C; maximum benefit of 50 visits per calendar year. Eligible expenses covered at 70% after deductible for approved visits over plan limit.*
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 50% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 50 visits per calendar year*
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; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 50 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services. For inpatient care 30 days per calendar year apply to mental health/ substance abuse treatment and applies to the Out of Pocket limit and the Stop-Loss provision..

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. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those 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.

Mental health/chemical dependency treatment expenses, including copayments, do count toward your calendar year out-of-pocket maximum and are subject to the stop-loss provision.

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% and for at least 30 days each year. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable. Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services.

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, coinsurance per visit. If you do not use UnitedHealthcare's recommended providers, you will be reimbursed for 50% of R&C for covered services after the deductible is met.

Note: There is a maximum benefit of 50 visits per calendar year for outpatient services, based on medical necessity. Eligible expenses will be covered at 50% after deductible for approved visits over plan limit for in-network services.

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 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 chart.

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" on page 107 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 84 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.

Oxford Health Plans Preferred Provider Organization (PPO)

(NY, NJ, and CT only)

The Oxford Preferred Provider Organization (PPO) is administered by Oxford Health Plans and is available in the New York, New Jersey, and Connecticut tri-state area.

Under the Oxford PPO Plan, you have the freedom to choose your doctor or healthcare facility when you need healthcare. 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. For a list of providers, visit the Oxford Health Plan Web site at www.oxhp.com or call Oxford member services at 1-800-760-4566.

Oxford PPO Health Plans (CT, NJ, NY only)

Type of service	Network	Out-of-network
Annual deductible		
▪ Individual	▪ $100	▪ $500
▪ Maximum per family	▪ $200	▪ $1,000
Annual out-of-pocket maximum (includes deductible)		
▪ Individual	▪ $2,000	▪ $4,000
▪ Maximum per family	▪ $4,000	▪ $8,000
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

Type of service	Network	Out-of-network
Preventive care (subject to frequency limits)		
▪ Well adult (including both travel and non-travel related immunizations)	▪ 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
▪ Well child (including both travel and non-travel related immunizations)		
▪ Cancer Screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy and PSA screening)		
▪ The $250 annual credit per person applies to out of network wellness services		
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		
▪ Semi-private 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 recommended 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)	▪ $50 copayment, waived if admitted for any reason within 24 hours	▪ $50 copayment, waived if admitted for any reason within 24 hours
▪ 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

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
Infertility treatment	▪ CT- Deductible and coinsurance apply to covered services up to a $10,000 lifetime maximum for in-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 in-network and out-of-network services combined. Pre-certification required. ▪ NY-Covered at 100% for services up to a $10,000 lifetime maximum for in-network and out-of-network services combined.	

Type of service	Network	Out-of-network
	▪ Contact Oxford for specific coverage details.	
Mental health and chemical dependency (refer to "Out-of-network coverage" on page 55)		

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 elect to use physicians or other providers in the network, you will need to satisfy an annual deductible ($100 individual/$200 family) before any benefit will be paid. Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-network.

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 $100 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the $200 family deductible, but no one person can apply more than the individual deductible ($100) 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 are $2,000 individual/$4,000 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 any expenses incurred for mental health/chemical dependency services, 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 Claim 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 ($2,000) to the family out-of-pocket maximums ($4,000).

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

- Pharmacy expenses;
- Any charges for mental health/chemical dependency services (these charges do however count toward the deductible); 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)

It is important when seeking primary care services to choose a provider from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in Oxford Health Plans are available directly from the Claim Administrator. You may call or visit the Claim Administrator's Web site — www.oxhp.com or call 800-760-4566

Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-network.

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 expenses that are received in-network.

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-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 detect health problems early.

- **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.

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 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.

See the “Glossary” on page 107 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 the Claim Administrator within 48 hours. If you are unable to do this, have a family member contact the Claim Administrator. Non-emergency services provided in the emergency room are not covered by the Oxford Health Plans.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a provider is not available. The centers usually have evening and weekend hours and generally 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on the Claim Administrator's web site. 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 Oxford Health Plan Claim Administrator to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claim 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 Plan or not approved by Oxford Health Plan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under Oxford Health Plan and are not payable by the Claim Administrator.

For information about how to file a claim or appeal a denied claim, see "Claims and appeals for Oxford Health Plans medical plans**"** in the *About Your Health Care Benefits* document.

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**"** in the *About Your Health Care Benefits* document.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible ($500 individual/$1,000 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 $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 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 $4,000 individual/ $8,000 family. This amount includes the ($500 individual and $1,000 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, any coinsurance charges for mental health/chemical dependency services, 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 ($4,000) to the family out-of-pocket maximum ($8,000).

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

- Expenses that exceed R&C;
- Pharmacy expenses;
- Any coinsurance charges for mental health/chemical dependency services; 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

Preventive care services are available in the Oxford Health Plans.

Each participant has a $250 annual credit toward all wellness services out of network. Thereafter, covered expenses are not subject to the deductible and 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 immunizations and well-child immunizations performed by non-network providers. Well 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:

- 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.

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.

See the “Glossary” on page 107 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 the Plan Administrator within 48 hours. If you are unable to do this, have a family member contact the Claim Administrator.

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

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and generally 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, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on the Claim Administrators' web sites. 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.

Mental health/chemical dependency – In and out of network

Oxford HealthPlans 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 also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

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

Action	Inpatient*	Outpatient
If you call the Plan and use its network provider/facility	Eligible expenses covered at 90% after deductible of the negotiated rate; maximum benefit of 30 days per calendar year. Eligible expenses covered at 70% after deductible for - days approved for medical necessity over plan limit.**	90% after deductible; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 70% after deductible for visits approved for medical necessity over plan limit.**
If you call the Plan but do not use its network provider/ facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year. Eligible expenses covered at 50% of R&C after deductible for days approved for medical necessity over plan limit.**	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year. Eligible expenses covered at 50% of R&C after deductible for visits approved for medical necessity over plan limit.**

* Inpatient pre-certification is required.

** Maximum benefits are combined for network and out-of-network services.

Note: Mental Health and chemical dependency maximums are combined.

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the plan medical necessity requirements, coverage limitations and deductibles. Your coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under Oxford HealthPlans.

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. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

Oxford HealthPlans pays benefits at the network level (90% of negotiated rate contracted with the Claim 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. There is a maximum benefit of 30 days per calendar year for inpatient mental health/chemical dependency services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Eligible expenses will be covered at 70% after deductible for approved visits over plan limit for in-network services and covered at 50% of R&C after deductible for out-of network services. 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 HealthPlans 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 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity. Eligible expenses will be covered at 70%

after deductible for approved visits over plan limit for in-network services and covered at 50% of R&C after deductible for out-of network services.

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral, however you are required to call Oxford HealthPlans within 48 hours after an emergency admission. Oxford HealthPlans behavioral health providers are available 24 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” on page 107 for a definition of medical necessity.

For more information about what your Plan covers, see “Covered services and supplies” on page 84. 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 pre-certification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

Prescription drugs

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.

Feature	Retail	Mail Order
Quantity available for each prescription or refill	Up to a 34-day supply. Retail not available after 3 fills of same drug.	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. Please call Plan for details.	

Covered drugs

The following drugs and products are covered under the prescription drug program:

- Federal legend 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) is covered with no age restrictions; and
- Botulinum Tox Type A or B (Botox / Myobloc).

Some drugs require pre-authorization. They include:

- Legend anti-obesity preparations;

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

If the prescribed medication must be pre-authorized, the pharmacy will let you know if additional information is required by the Plan. You or the pharmacy can then ask your doctor to call a special toll-free number. This call will initiate a review that typically takes one to two business days. You and your physician will be notified when the review is completed. If your medication is not approved, you will have to pay the full cost of the prescription drug.

There are also coverage limits for 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 prescription drug program:

- Non-federal legend drugs;
- Contraceptive jellies, creams, foams, devices, or implants;
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Relenza ;
- Tamiflu ;
- Gardisil and Zostavax (vaccinations covered under medical; therefore, provider must bill under medical plan)
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices or appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or 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 which 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 which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- 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.

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 of the document provides a description of the medical benefit information that is available to you as an HMO participant. This should be read together with the *About Your Health Care Benefits* document, the HMO Fact Sheets and the HMO Certificate of Insurance listed in "2009 Insured HMOs" on page 67. There is a separate HMO Fact Sheet and HMO Certificate of Insurance for each fully insured HMO:

- *About Your Health Care Benefits* document — provides you with information about plan eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.
- HMO Fact Sheets — provide a brief summary of the benefits available through each HMO and are included in this document. The fact sheet for each HMO also has a link to a provider directory for each HMO, so that you can identify the healthcare 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 their plan. If you do not receive your Certificate of Insurance, call your HMO directly at the telephone number shown on the HMO fact sheet or on your ID card. The Certificate of Insurance for each HMO is also 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 plan) 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 all the HMOs offered by Citi, Fact Sheets and the Certificate of Insurance for each HMO, see "2009 Insured HMOs" on page 67. 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.

It is important to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the plan.

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

All the materials described above make up the Plan document for Citi's fully insured HMOs. It 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.

Citi HMO Typical Plan Design features

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 $100 for an individual/$200 maximum for a family. 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 $2,000 for an individual/$4,000 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. Call your HMO for more information.

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

As a reminder, benefits vary depending on the HMO you select. You can find out more information about the specific benefits for each HMO by reviewing the HMO fact sheet and the Certificate of Insurance.

If you have questions or concerns about specific covered services, you can contact the HMO directly or contact Citi's HMO Information Line at 1-800-422-6106.

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.

For many HMOs, when you enroll in the plan, every covered family member must 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 Fact Sheet available under "Insured Health Maintenance Organizations (HMOs)" beginning on page 63, then clicking on the link to the HMO's Web site. Generally, if you do not choose a PCP, one will be selected for you.

Your options for choosing a PCP depend on the plan 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

In most HMOs, when you need a specialist, you will have to obtain a referral from your HMO or the services are not 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 go to a specialist without one, you may be responsible for the full cost of your care. You generally 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. Hospital services generally require advance approval from the HMO. Your PCP may help to coordinate the approval.

See the HMO Fact 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 (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 Fact Sheet and Certificate of Insurance for more information about maternity coverage.

Contact the Benefits Service Center directly within 31 days to add your new born child to your coverage. The Health Plans will not cover the child after 31days.

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.

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.

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 plan.

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

Benefit Limitations

Covered services, exclusion and limitations vary by HMO. It is important to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the plan.

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.

2009 Insured HMOs

The following list identifies the fully insured HMOs offered by Citi for 2009 in each state. Please note that the inclusion of an HMO option in a state listing 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 listed in the HMO Fact Sheet.

Some HMOs are still completing their 2009 Certificates of Insurance. The 2009 Certificates will be posted as soon as they are available. Meanwhile, for those HMOs, the 2008 Certificate is posted instead.

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 (formerly IHC Health Plans) — Fact Sheet, Certificate of Insurance
Iowa	Coventry Health Care of Iowa — Fact Sheet, Certificate of Insurance
	Sanford Health Plan (formerly Sioux Valley Health Plans) — Fact Sheet, Certificate of Insurance
Maryland	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance
Minnesota	Sanford Health Plan (formerly Sioux Valley Health Plans) — 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 (formerly Sioux Valley Health Plans) — Fact Sheet, Certificate of Insurance
Utah	SelectHealth (formerly IHC Health Plans) — Fact Sheet, Certificate of Insurance
Virginia	Kaiser FHP of the Mid-Atlantic States — Fact Sheet, Certificate of Insurance

Prescription drug program

The prescription drug program described in this section is administered by Express Scripts, and applies to participants enrolled in one of the ChoicePlans, High Deductible Health Plans, Hawaii Health Plan. HMO or Oxford PPO Health Plans participants are not eligible for the prescription drug

benefits described in this section. Oxford PPO Health Plans and each HMO has its own retail and mail-order pharmacy program.

- The prescription drug program gives you access to the Express Scripts Home Delivery for your long-term prescription needs, as well as a nationwide network of retail pharmacies for your short-term prescriptions.

Prescription Drug Program for ChoicePlans

Feature	Retail	Express Scripts Home Delivery
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. Retail not available after 3 fills of same drug.	Up to a 90-day supply with refills for up to one year.
Deductible		
▪ Individual ▪ Maximum per family	▪ $100 ▪ $200	▪ $0
Your copayment for each prescription or refill*	At network pharmacies:	
	▪ $5 for a generic drug.	▪ $12.50 for a generic drug.
	▪ $30 for a preferred brand-name drug.	▪ $75 for a preferred brand-name drug.
	▪ 50% of the cost of the drug with a minimum payment of $50 to a maximum payment of $150 for a non-preferred brand-name drug.	▪ 50% of the cost of the drug with a minimum payment of $125 to a maximum payment of $375 for a non-preferred brand-name drug.
	Note: 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, plus you will pay the generic copayment.	Note: 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, plus you will pay the generic copayment.
	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.	

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

Prescription Drug Program for High Deductible Health Plans

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. Retail not available after 3 fills of same drug.	Up to a 90-day supply with refills for up to one year.
Deductible: For the High Deductible Health Plans: A combined deductible applies to both medical services and prescription drug services. The deductible is waived for certain drugs classified as preventive. For a list of these preventive medications, call Express Scripts at 1-800-227-8338 or visit www.express-scripts.com.		
Your copayment for each prescription or refill*	At network pharmacies:	
	▪ $5 for a generic drug.	▪ $12.50 for a generic drug.
	▪ $30 for a preferred brand-name drug.	▪ $75 for a preferred brand-name drug.
	▪ 50% of the cost of the drug with a minimum payment of $50 to a maximum payment of $150 for a non-preferred brand-name drug.	▪ 50% of the cost of the drug with a minimum payment of $125 to a maximum payment of $375 for a non-preferred brand-name drug.
	Note: 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, plus you will pay the generic copayment.	Note: 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, plus you will pay the generic copayment.
	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.	

Prescription Drug Program for the Hawaii Health Plan

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. Retail not available after 3 fills of same drug.	Up to a 90-day supply with refills for up to one year.
Deductible		
▪ Individual ▪ Maximum per family	▪ $50 ▪ $100	▪ $0
Your copayment for each prescription or refill*	At network pharmacies:	
	▪ $10 for a generic drug.	▪ $25 for a generic drug.
	▪ $20 for a preferred brand-name drug.	▪ $50 for a preferred brand-name drug.
	▪ 50% of the cost of the drug with a minimum payment of $40 to a maximum payment of $100 for a non-preferred brand-name drug.	▪ 50% of the cost of the drug with a minimum payment of $100 to a maximum payment of $250 for a non-preferred brand-name drug.
	Note: 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, plus you will pay the generic copayment.	**Note:** 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, plus you will pay the generic copayment.
	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.	

Express Scripts Preferred Prescriptions Formulary is a list of drugs carefully selected by an independent pharmacy and therapeutic committee to help maintain quality care while saving money for both you and Citi. Since the list of preferred brand-name drugs is reviewed on a quarterly basis, your copayment for a drug may change during the year. To see whether your prescription is still on the list of preferred brand-name drugs, call Member Services at 1-800-227-8338 or visit www .express-scripts.com. Prescription drugs for the treatment of infertility are covered with a lifetime maximum of $7,500.

Retail pharmacy

When you enroll in a Health Plan, you will be issued a prescription ID card. When you present the prescription ID card at a network pharmacy, you will pay a copayment for up to a 34-day supply of your prescription. However, for medications known as "maintenance drugs" you take on a regular basis for conditions such as asthma, heartburn, blood pressure and high cholesterol, you will pay 100% of the cost of the drug after three fills unless you use the mail order pharmacy option.

There is a 45 day grace period from the effective date of your enrollment, during which time you will be reimbursed for 100% of the covered drug cost less the network copayment without presenting your card. Thereafter, if you fail to present your prescription ID card at a network pharmacy at the time the prescription is filled, you will be reimbursed for 50% of the submitted price of the drug if the annual deductible has been met. In either case, you must pay the entire cost of the prescription and then submit a claim form. The deductible must be satisfied during the grace period.

You must present your prescription ID card at the network pharmacy to take advantage of the network copayments. If you use an out-of-network pharmacy, you must pay the entire cost of the prescription and then submit a claim form. You will be reimbursed for 50% of the submitted price of the drug if the annual deductible has been met. However, if you use an out-of-network pharmacy during an emergency care situation, reimbursement for the cost, except the network deductible, may be available. You should contact Member Services at 1 800-227-8338 for information regarding coverage in emergencies.

You can locate a network pharmacy by calling Member Services at 1-800-227-8338 or by visiting the Web site at www.express-scripts.com.

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 cash price is less than the copayment, you will pay the pharmacy cash price. Benefits do not start until the annual deductible has been met. Refer to the chart under "Prescription drug program" on page 67.

Some drugs may require a letter from your physician providing additional information in order to be covered. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

Send all completed claim forms to:

Express Scripts Pharmacy
P.O. Box 66583
St. Louis, MO 63166

Express Scripts Home Delivery

Express Scripts Home Delivery fills prescriptions for up to a 90-day supply of maintenance drugs.

Refer to the chart under "Prescription drug program" on page 67.

To take advantage of the savings through home delivery, the original prescription should indicate that up to a 90-day supply is needed, not including refills.

Home delivery forms can be obtained by calling Member Services at 1-800-227-8338 or visiting the Web site at www.express-scripts.com.

Send all completed home delivery pharmacy service order forms to:

Express Scripts Pharmacy
Home Delivery Service
P.O. Box 510
Bensalem, PA 19020-0510

"Mandatory" mail-order program – Express Scripts Home Delivery

For a prescription you take on an ongoing basis (more than three months), you may use a retail pharmacy for your initial fill (34-day supply) and up to two refills, i.e., three fills in total. Thereafter, if you remain on that medication, you must order subsequent refills through Express Scripts Home Delivery or pay the entire cost of the drug yourself at the retail pharmacy.

Covered drugs

The following drugs and products are covered under the prescription drug program:

- Federal legend 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) is covered with no age restrictions; and
- Botulinum Tox Type A or B (Botox / Myobloc).

Some drugs require pre-authorization. They include:

- Legend anti-obesity preparations;
- Amphetamines at age 19 and over;
- Retin-A/Avita (cream only) at age 35 and over;

- Botulinum Tox Type A or B (Botox / Myobloc); and
- Zelnorm.

Prior authorization

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 Web site at www.express-scripts.com. Your pharmacist also can 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.

If the prescribed medication must be pre-authorized, the pharmacy will let you know if additional information is required by the Plan. You or the pharmacy can then ask your doctor to call a special toll-free number, 1-800-224-5498. This call will initiate a review that typically takes one to two business days. You and your physician will be notified when the review is completed. If your medication is not approved, you will have to pay the full cost of the prescription drug.

Specialty medication

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. You can purchase a 30-day supply of specialty medication through CuraScript.

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

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 to the pharmacy or to Express Scripts before it can dispense your medication(s).

'Generics Preferred'

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.

Medical necessity review (for non-formulary drugs)

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.

Aetna High Deductible Health Plan information

The High Deductible Health Plan only covers the cost of certain preventive drugs without having to meet your combined medical and pharmacy deductible. For these prescriptions 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 also can visit www .express-scripts.com. From the Benefit Overview menu, select "Coverage & Copayments."

If, for 2008, 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 2009, visit https://member.express-scripts .com/preview/citigroup2009 to view the 2009 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.**

Step Therapy

Brand name medications known as Non-Steroidal Anti-inflammatory (NSAID) and COX2 will require Step Therapy. Examples of these medications are Celebrex and Naproxen. The Plan requires you to try an equally effective but lower cost generic prior to filling the Brand name medication before the Plan will pay for the medication.

If you have a discontinuance or lapse in therapy greater 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

There are also coverage limits for 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 prescription drug program:

- Non-federal legend drugs;
- Contraceptive jellies, creams, foams, devices, or implants;
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Relenza*;
- Tamiflu*;
- Gardisil and Zostavax (vaccinations covered under medical; therefore, provider must bill under medical plan)
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices or appliances;

* Express Scripts Home Delivery exclusion only; covered by retail pharmacy.

- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or 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 which 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 which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- 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.

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 health plan. Be sure to read the sections that apply to the plan available to you.

Aetna plans

If you are enrolled in an Aetna plan (ChoicePlans), 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 the carrier of emergency hospitalization or other emergency services occurring outside the U.S.

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 84 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;
- For the Aetna ChoicePlan (Open Choice POS II Plan), you must notify the plan to certify inpatient confinement for delivery of a child. This is to certify a length of stay 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, 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 do 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**"** in the *About Your Health Care Benefits* document.

Empire BlueCross BlueShield plans

If you are enrolled in a Empire BlueCross BlueShield plan ChoicePlans, you should call Empire BlueCross BlueShield to precertify any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services are recommended to be precertified at least 14 days in advance. Some outpatient procedures must be precertified at least five days in advance. Empire BlueCross BlueShield should be notified of emergency admissions within 48 hours of the admission.

Inpatient confinements

For inpatient confinement, you are encouraged to call Empire BlueCross BlueShield 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 Empire BlueCross BlueShield again as soon as the admission date is set.

You are encouraged to 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; or acute care inpatient rehabilitation facility;
- Home health care, home infusion therapy;
- Private duty nursing; and
- Maternity stays that exceed 48 hours after a normal vaginal delivery, or 96 hours after a caesarean section.

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

Outpatient surgery

Organ/tissue transplants

- You are encouraged to call Empire BlueCross BlueShield at least 14 working days prior to the service being provided.

Mental health/chemical dependency

You are encouraged to call Empire BlueCross BlueShield for precertification before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You are encouraged to notify 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 84 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.

If you or your physician do 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**"** in the *About Your Health Care Benefits* document or call 866-290-9098.

Out-of-Network Services (for the ChoicePlans)

When you receive care for any Inpatient Confinement, Organ and Tissue Transplant, Skilled Nursing Facility, All Home Healthcare, and Air Ambulance with an out-of-network provider you must precertify with Blue Cross Blue Shield prior to services rendered to avoid any precertification penalties.

Oxford Health Plans

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.

In Network services: please keep in mind that your PCP or other network provider will handle the precertification process for you when you receive any in-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.

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 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 do not agree with Oxford HealthPlans determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for Oxford Health Plans medical plans**"** in the *About Your Health Care Benefits* document.

Hawaii Health Plan

When you receive care from any provider, whether in-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 do 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**"** in the *About Your Health Care Benefits* document.

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) guidelines, or, for network services, the negotiated rates of the Plan.

You and your physician decide which services and supplies are required, but the Plan only pays for the following covered services and supplies that are medically necessary as determined by the Claim 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 Claim 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+
- **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)** — Persons born after 1956 - two doses measles with additional doses as MMR; Persons 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 first dose and third dose no earlier than two months after first dose and four months after second dose)
- **Meningococcal** — Meningitis - Only those at risk. If at increased risk, one dose (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
- **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 Claim 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, 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 ChoicePlans** 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 up to $1,200 once every 36 months
- 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). 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.

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage 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);
- 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 ChoicePlans** and **Empire BlueCross BlueShield ChoicePlans**, bereavement counseling is covered under the mental health benefit.
- **Oxford Health Plans** will cover up to fifteen 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; homemaker, caretaker or respite care. If the member's contract with Oxford terminates, 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;
- Pre-operative 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).

Infertility treatment

Infertility benefits are provided by the following Health Plans: ChoicePlans, HDHP, 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 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 drug program on page 67.
- Covered services do not include: the costs associated with surrogate mothers, 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 the Oxford Health Plan you are enrolled in for details.

HMO Plans: Each offers different infertility coverage and limits, if at all: Please 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 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** and **Empire BlueCross BlueShield ChoicePlan** 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, pre-certification 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 Health Plan directly.

Dietician/Nutritionist coverage is also available for Morbid Obesity. Please see the Dietician/Nutritionist section.

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 only covered 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;

- TMJ surgery; and
- Anesthesia for dental services is covered by Empire BlueCross BlueShield 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 or due to an underlying medical reason (first round only all other services after first submit to dental) to sound and natural teeth that happened to you or your dependent while covered under this Plan:

- 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 Claim Administrator must be notified at least 17 (10 Empire BlueCross Blue Shield) business 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 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 Claim 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 their quality of care and successful clinical outcomes. Under the Aetna ChoicePlan, a transplant will be covered as In-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 them 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 Quality Center for Transplants (BQCT) is used, the transplant will be covered at 100% with access to the travel and lodging benefit. Transplants performed at a participating, non-BQCT facility are covered at 90%, all other facilities are covered at 70%, with no access to the travel and lodging benefit. Travel and Lodging is covered only if a BQCT facility is used.

Medical care and treatment

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

- Pre-transplant 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 does not apply to the **Aetna and Empire plans**.)
- Transportation and lodging

When available, the Plan will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging, and meals 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 and meals for the patient (while not confined) and one companion. Benefits are paid at per diem rate of $50 for one person or $100 a day for two people. (For **Aetna plans**, a maximum of $50 per person—$100 for patient and companion combined — per night is paid towards lodging expenses. Meals are not covered.) For **Empire BlueCross BlueShield** the maximum is $125 per day.
- 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, and lodging and meal expenses will be reimbursed at the $100 per diem rate; **Empire BlueCross BlueShield** has a $125 per diem rate;
- There is a combined overall lifetime maximum of $10,000 per covered person for all transportation, lodging, and meal expenses incurred by the transplant recipient and companion and reimbursed under the Health 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 Health Plan if and to the extent covered by the Health 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 have specifically contracted and designated to perform these procedures to be eligible for in-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
- Pancreas Transplant

Oxford does not cover travel expenses, lodging, meals, comfort items, or other accommodations for donor or guests.

For more information, contact your Claim 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 97.

Outpatient physical therapy

See “Rehabilitation Therapy” on page 97.

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 and Empire BlueCross BlueShield ChoicePlan** there is a combined network and out-of-network maximum benefit of 200 visits per calendar year (combined with

home health care visits). One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered.

- For **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.
- For **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 Health 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 semi-private 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.
- **ChoicePlans:** Spinal Manipulation therapy limited to 20 visits per calendar year. All other therapies combined are limited to 60 visits per calendar year for restorative care.
- **Hawaii Health Plan**: Cover at least 30 days of each type of therapy each calendar year for restorative care, with a separate chronic/developmental 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 semi-private 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 97.

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;
  - Accidental injury that happens while the person is covered under the Health 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 their own behalf. (**Aetna and Empire** cover assistant surgeon services for certain surgeries. **Aetna** covers registered nurses acting as assistant surgeons for certain surgeries. Contact Empire for information as to which providers qualify as assistant surgeons.)

Multiple surgical procedures

If you're 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:

- Primary procedure: The Plan will allow 100% of the negotiated or reasonable and customary fee.
- Secondary procedure: The Plan will allow 50% of the negotiated or reasonable and customary fee.
- Tertiary and additional procedures: The Plan will allow 50% of the negotiated or reasonable and customary 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 won't be covered. An incidental surgery is a procedure performed at the same time as a primary procedure and requires little additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Covered expenses for multiple surgical procedures are subject to the Claim Administrator review.

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 examinations and immunizations, based on guidelines from the American Medical Association.

Wellness benefit

Covered expenses include:

- Routine physical examination (including well-woman exams) are covered once per calendar year;
- Immunizations (including non-travel related immunizations);
- Vision examination is covered once every 24 months
- Smoking cessation and
- Weight control

There is a $250 calendar year maximum that applies to non-network services per covered family member. This maximum does not apply to wellness visits to network providers, for well-child care and immunizations, or for routine care under Hawaii Health Plan.

Women's Health and Cancer Rights Act of 1998

Your group health plan benefits described in this document provide benefits for mastectomy-related services, and the complications resulting from a mastectomy (including lymphedema), as required by the Women's Health and Cancer Rights Act of 1998. These benefits include reconstruction and surgery to achieve breast symmetry, and prostheses. For more information, please refer to "Surgery" on page 98 and your medical insurance carrier booklet. Normal plan deductibles and coinsurance may apply.

For information on what is not covered, see "Exclusions and limitations" on page 101.

Exclusions and limitations

There are services and expenses that are not covered under the Non-HMO/PPO Health 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 84;
- 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 Claim Administrator;
- Beam neurologic testing;
- Biofeedback, except as specifically approved by the Claim Administrator;
- Blood, blood plasma, or other blood derivatives or substitutes, except as listed in "Covered services and supplies" on page 84;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Claim 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 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 which are performed as a treatment for acne. However, the Plan covers reconstructive surgery, as outlined in "Covered services and supplies" on page 84;
- 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 or Empire BlueCross BlueShield);
- 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, implants, See "Covered services and supplies" on page 84 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 84 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 Claim Administrator, unless approved by the Claim 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 Claim Administrator has determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. Refer to the "Glossary" on page 107 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 pre-authorized by the Claim 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:** not covered; however, discounts on alternative medicine and treatment are available through the Empire SpecialOffers Program. Visit Empire's website, www.empireblue .com/citi for information on 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 Claim Administrator;
- Implantable drugs (other than contraceptive implants);
- Infertility services, except as described under "Covered services and supplies" on page 84. The Plan does not cover charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm; does not cover surrogate mothers or any charges associated with them.
- Inpatient private duty or special nursing care. Outpatient private duty nursing services must be pre-authorized by the Claim Administrator
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs; (**Oxford** offers a $200 reimbursement every 6 months for employees that can prove they have had 50 gym visits in that time period and $100 every 6 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 84;
- 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 examinations, 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 corn;
- 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 the parent or grandparent of you or your 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 examinations 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 examinations 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 Claim 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;
  - 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;
- Treatment of injuries sustained while committing a felony, assault, or during a riot or insurrection;
- 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.

Glossary

The following definitions apply to benefits provided under the Plan, unless clearly indicated otherwise.

Accredited school or college. An accredited secondary school, junior college, college, or university, or a state or federally accredited trade or vocational school.

Ambulatory surgical center. A specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who devotes full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one postanesthesia recovery room;
  - It is equipped to perform diagnostic x-ray and laboratory examinations or has arranged to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;
  - It provides the full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the postanesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center for the purposes of the Plan.

Birth center. A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; and
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;

- It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;
- It has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
- It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN);
- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary; and
- It is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

A birth center that is part of a hospital, as defined herein, will be considered a birth center for the purposes of the Plan.

Brand-name drug. A drug that is under patent by its original innovator or marketer.

Calendar year. January 1 through December 31 of the same year. For new enrollees, the calendar year is the effective date of their enrollment through December 31 of the same year, unless otherwise provided in the open enrollment materials.

Chiropractic care. Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The following are not considered to be chiropractic care: chiropractic appliances, services related to the diagnosis and treatment of jaw joint problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders, or services for treatment of strictly non-neuromusculoskeletal disorders.

Claim Administrator. Aetna, Empire BlueCross BlueShield, Oxford PPO Health Plans, Hawaii Health Plan and Express Scripts, and any other party designated as a claims fiduciary pursuant to a contractual relationship and as authorized by the Plans Administration Committee of Citi Inc. The Claim Administrator does not insure the benefits described in this document.

Comprehensive outpatient rehabilitation facility. A facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured or sick persons and that fully meets one of the following two tests:

- It is approved by Medicare as a comprehensive outpatient rehabilitation facility; or
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
  - Services of physicians who are available at the facility on a full- or part-time basis;

- Physical therapy; and
- Social or psychological services;
- It has policies established by a group of professional personnel (associated with the facility), including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes and provides for the carrying out of such policies by a full- or part-time physician;
- It has a requirement that every patient must be under the care of a physician; and
- It is established and operates in accordance with the applicable licensing and other laws.

Cosmetic surgery. Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements, and teeth whitening.

Covered expenses. Those expenses listed under "Covered services and supplies" on page 84.

Covered family members or covered person. The employee and the employee's legal spouse and/or dependent children, or qualified domestic partner who are covered under the Plan.

Custodial care. The care (including room and board needed to provide that care) given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care include help in walking and getting out of bed, assistance in bathing, dressing, and feeding, or supervision over medication that normally could be self-administered.

Designated transplant facility. A facility designated by the Claim Administrator to render medically necessary covered services and supplies for qualified procedures under the Plan.

Emergency care. Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy;
- Bodily function would be seriously impaired; and
- There would be serious dysfunction of a bodily organ or part.

Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

ERISA. The Employee Retirement Income Security Act of 1974, as amended.

Experimental, investigational, or unproven services. Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Health Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;

- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Claim Administrator, in its judgment, may deem an experimental, investigational, or unproven service covered under the Plan for treating a life-threatening sickness or condition, if it is determined by the Claim Administrator that the experimental, investigational, or unproven service at the time of the determination:

- Is proved to be safe with promising efficacy;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Fiduciary. A person who exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. The "named fiduciary" for the Plan is the Plans Administration Committee of Citi Inc., except to the extent fiduciary authority has been delegated by this document or otherwise to Claim Administrators or others.

Generic drug. Equivalent medications that contains the same active ingredient and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency. An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all of the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (RN) or it has nursing care by a registered nurse (RN) available; and
  - Its employees are bonded, and it maintains malpractice insurance.

Hospice. An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24-hour-a-day, seven-day-a-week service;
  - It is under the direct supervision of a duly qualified physician;
  - It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
  - The main purpose of the agency is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A hospice that is part of a hospital will be considered a hospice for the purposes of the Plan.

Hospital. An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all of the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured person by or under the supervision of a staff of duly qualified physicians;
  - It continuously provides, on the premises, 24-hour-a-day nursing service by or under the supervision of registered graduate nurses; and
  - It is operated continuously with organized facilities for operative surgery on the premises.

Injury. An accidental physical injury to the body caused by unexpected external means.

Intensive care unit. A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

Licensed counselor. A person who specializes in mental health and chemical dependency treatment and is licensed as a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Lifetime. A word appearing in the Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which you and your eligible dependent are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

Medically necessary or medical necessity. Health care services and supplies that are determined by the Claim Administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Health Plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician;
- Must be provided by a physician, hospital or other covered provider under the Health Plan;
- With regard to a person who is an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- It must not be primarily scholastic, vocational training, educational or developmental in nature, or experimental or investigational;
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this summary relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Health Plans.

Medicare. The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment. Treatment for both of the following:

- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any sickness where the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity. A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age, and mobility as the covered person. For **Aetna and Empire plans**, the BMI is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Network pharmacy. Registered and licensed pharmacies, including mail-order pharmacies that participate in the network.

Network provider. A provider that participates in a ChoicePlan or a Plan network, or one of the HMO/PPOs.

Nonoccupational disease. A disease that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from a disease that does.

A disease will be deemed to be nonoccupational regardless of cause if proof is furnished that the person:

- Is covered under any type of Workers' Compensation Law; and
- Is not covered for that disease under such law.

Nonoccupational injury. An accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit, or
- Result in any way from an injury that does.

Non-preferred brand-name drug. A brand-name drug that is not a formulary drug. See the definition of preferred brand-name drug.

Nurse-midwife. A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse; and
- A person who has completed a program approved by the state for the preparation of nurse-midwives.

Nurse-practitioner. A person who is licensed or certified to practice as a nurse-practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse; and
- A person who has completed a program approved by the state for the preparation of nurse-practitioners.

Occupational therapy. Services that improve the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored.

Other services and supplies. Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-network hospital. A hospital (as defined) that does not participate in a ChoicePlan or Health Plan network, or an HMO/PPO.

Out-of-network pharmacy. A pharmacy other than an Express Scripts network pharmacy.

Out-of-network provider. A provider that does not participate in a ChoicePlan or Health network, or an HMO/PPO.

Outpatient care. Treatment including services, supplies, and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient or services rendered in a physician's office, laboratory or x-ray facility, an ambulatory surgical center, or the patient's home.

Physical therapy. Services that are designed to restore an individual to a level of function present prior to an illness or accidental injury.

Physician. A legally qualified and licensed:

- Doctor of Medicine (MD);
- Doctor of Chiropody (DPM; DSC);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medical Dentistry (DMD);
- Doctor of Osteopathy (DO); or
- Doctor of Podiatry (DPM).

Care provided by Christian Science practitioners is covered as an out-of-network benefit under the ChoicePlans.

Plan. The Citi Health Benefit Plan, as amended from time to time. For ERISA reporting purposes, the Plan number is Plan 508.

Plan Administrator. The Plans Administration Committee of Citi Inc.

Plan year. January 1 – December 31.

Preadmission tests. Tests performed on a covered person in a hospital before confinement as a resident inpatient provided they meet all of the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a physician after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the physician and confirmed by the hospital; and
- The covered person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the covered person's condition that precludes the surgery.

Preferred brand-name drug. A drug that is prescribed from a list of medications preferred for its clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs. Any drugs that cannot be dispensed without a doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs. This is any medicinal substance that the federal Food, Drug, and Cosmetic Act requires to be labeled "Caution — federal law prohibits dispensing without prescription";
- Drugs that require a prescription under state law but not under federal law;
- Compound drugs having more than one ingredient, and at least one of the ingredients has to be a federal legend drug or a drug that requires a prescription under state law;
- Injectable insulin; and
- Needles and syringes.

Primary care physician (PCP). A physician in general practice or who specializes in pediatrics, family practice, or internal medicine who has agreed with the Claim Administrator to act as the entry point to the health care delivery system and as the coordinator of member care. The PCP is not an agent or employee of the Claim Administrator or Citi Inc.

Psychiatrist. A physician who specializes in mental, emotional, or behavioral disorders.

Psychologist. A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist; or
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable and customary charge (R&C). Any charge that, for services rendered by or on behalf of a non network physician, does not exceed the amount determined by the Claim Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claim Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claim Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

In some circumstances, **Aetna** may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the reasonable charge is the rate established in such agreement.

Rehabilitation facility. A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Room and board. Room, board, general-duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

Self-insured or self-funded plan. A plan in which no insurance company or service plan collects premiums and assumes risk.

Sickness. Bodily disorder or disease. The term “sickness” used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility. A facility, if approved by Medicare as a skilled nursing facility, is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed physician or registered nurse (RN) who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day skilled nursing care of sick and injured persons at the patient’s expense during the convalescent stage of an injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is authorized to administer medication to patients on the order of a licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Plan.

Treatment center. A facility that provides a program of effective mental health and chemical dependency treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a physician and the Claim Administrator;
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;
- It provides at least the following basic services:
- Room and board (to the extent that this Plan provides inpatient benefits at a Treatment Center);
- Evaluation and diagnosis;
- Counseling by a licensed provider; and
- Referral and orientation to specialized community resources.

Treatment centers that qualify as a hospital are covered as a hospital and not as a treatment center.

Urgent Care. Conditions or services that are non-preventive or non-routine, and needed in order to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Urgent Care Facility/Center: Aetna: Urgent care is the delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Often urgent care centers are not open on a continuous basis, unlike a hospital emergency room which would be open at all times. **Empire BlueCross BlueShield**: A facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. **Oxford:** A medical care facility that provides care for a condition that needs immediate attention to minimize the severity and prevent complications, but is not a medical emergency. Urgent Care Facilities are covered in or out of the service area. Precertification is not required for in plan urgent care treatment when provided by facilities that are specifically contracted by Oxford as urgent care providers. Members should contact the number on the back of their ID Cards for instructions.

Utilization review. A review and determination as to the medical necessity of services and supplies.