Citi Health Benefit Plan

Amended and Restated as of January 1, 2009

Medical Benefits

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 Citi Benefits Center at ConnectOne at 1-800-881-3938 and select the Health and Welfare 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) ▪ 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; 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 "Mental health/chemical dependency – In and out of network" on page 22)		

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 "Mental health/chemical dependency – In and out of network" on page 22)		

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.**
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
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)		

Type of service	Network	Out of Network
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
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 30)		

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
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 30)		

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., the setup fee and monthly account maintenance fees will be waived for Citi employees. "Establish" an HSA account at Citibank means you apply for an account and meet certain credit and "know your customer" requirements.

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 45	

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

Type of service	Network	Out-of-network
Professional care (in office)		
▪ PCP visits	▪ 90% after deductible	▪ 70% of R&C after deductible
▪ Specialist visits	▪ 90% after deductible	▪ 70% of R&C after deductible
▪ Allergy treatment	▪ 90% after deductible for the first office visit; 100% for each additional injection if office visit fee is not charged	▪ 70% of R&C after deductible
Preventive care (subject to frequency limits)		
▪ Well adult (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
▪ 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

Type of service	Network	Out-of-network
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
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

Type of service	Network	Out-of-network
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.	
	▪ Contact Oxford for specific coverage details.	
Mental health and chemical dependency (refer to "Mental health/chemical dependency – In and out of network" on page 57)		

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

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

State	HMO
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.

Feature	Retail	Express Scripts Home Delivery
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

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.

Feature	Retail	Express Scripts Home Delivery
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

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	▪ $50	▪ $0
▪ Maximum per family	▪ $100	

Feature	Retail	Express Scripts Home Delivery
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.