Medical

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

The following information applies to all Citi medical options. Your Benefits Resources™ lists the medical options available to you based on your home zip code.

Depending on your location, you may choose from one of the following medical options or an HMO:

- ChoicePlan 500 administrated by Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan);
- High Deductible Health Plan administrated by Aetna (Choice POS II Open Access) and Empire BlueCross BlueShield (PPO Preferred Provider Organization plan); or
- Oxford Health Plans PPO (available in the Connecticut, New Jersey, and New York tri-state area only).

HMOs:

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

Contents

Administrator of the ChoicePlan and Preferred Provider Organization (PPO)

ChoicePlan 500 is administered by Aetna and Empire BlueCross BlueShield throughout the United States. The ChoicePlan 500 design is essentially the same no matter which vendor administers the Plan. The PPO is administered by Oxford Health Plans (a United HealthCare company) and offered in CT, NJ, and NY only. The ChoicePlan 500 and the Oxford Health Plans PPO are self-insured, meaning these plans are not subject to state laws and Citi pays the claims incurred.

Medical options at a glance

For HMO information, visit "2013 insured HMOs" on page 100 or see the Health Plan Comparison Charts on Your Benefits Resources™ (YBR™). To access YBR™, visit Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. **Note:** In ChoicePlan 500 and the High Deductible Health Plan, precertification is required for certain procedures and services both network and out-of-network. Penalties may apply. Call your plan at the number listed on the back of your ID card for details.

For in-network covered expenses, the Plan pays a percentage of discounted rates while for out-of-network charges, the Plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	**Out-of-network**	**Network**	**Out-of-network**
Annual deductible (network and out-of-network combined)				
Individual	$500	$1,500	$500	$1,500
Maximum per family	$1,000	$3,000	$1,000	$3,000
Annual out-of-pocket maximum (includes deductible; network and out-of-network combined)				
Individual	$3,000	$6,000	$3,000	$6,000
Maximum per family	$6,000	$12,000	$6,000	$12,000
Lifetime maximum	None	None	None	None

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	**Out-of-network**	**Network**	**Out-of-network**
Professional care (in office)				
Doctor/primary care physician (PCP) visits	90% after deductible**	70% of MAA after deductible**	90% after deductible**	70% of MAA after deductible**
Specialist visits	90% after deductible; **Aetna:** 95% after deductible** for Aexcel specialists	70% of MAA after deductible**	90% after deductible**	70% of MAA after deductible**
Preventive care (subject to frequency limits)				
Well-adult visits	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
Well-child visits	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
Adult and child routine immunizations	100%, not subject to deductible	70% of MAA, not subject to deductible	100%, not subject to deductible	70% of MAA, not subject to deductible
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible	100%, not subject to deductible	100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
Contraceptive devices	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	70% of MAA after deductible**	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	70% of MAA after deductible**

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	**Out-of-network**	**Network**	**Out-of-network**
Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	70% of MAA after deductible**	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	70% of MAA after deductible**
Hospital emergency room (No coverage in any medical option if not a true emergency)				
	100% after $100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization; not subject to annual deductible)		100% after $100 copayment (waived if admitted within 24 hours of emergency room use; precertification required for hospitalization; not subject to annual deductible)	
Urgent care center				
	90% after deductible**	90% of MAA after deductible** **Note:** For Empire BCBS coverage is 90% of billed charges (not MAA).	90% after deductible**	90% of MAA after deductible**
Hospital (inpatient and outpatient services)				
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	90% after deductible**; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible**; precertification required for certain outpatient procedures	90% after deductible**; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible**; precertification required for hospitalization and certain outpatient procedures
Non-routine outpatient				
Lab, radiology, and X-ray	90% after deductible**; precertification required for certain outpatient procedures	70% of MAA after deductible**; precertification required for certain outpatient procedures	100%, not subject to deductible; precertification required for certain outpatient procedures	70% of MAA after deductible**; precertification required for certain outpatient procedures
Mental health and substance abuse				
Inpatient	90% after deductible**; precertification required	70% of MAA after deductible**; precertification required	90% after deductible**; precertification required	70% of MAA after deductible**; precertification required
Outpatient	90% after deductible**; precertification recommended	70% of MAA after deductible**, precertification recommended	90% after deductible**; precertification recommended	70% of MAA after deductible** precertification recommended

	ChoicePlan 500 Administered by Aetna and Empire BlueCross BlueShield		Oxford Health Plans PPO (Available in CT, NJ, and NY only)	
	Network	**Out-of-network**	**Network**	**Out-of-network**
Therapies				
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year for network and out-of-network combined; you may be eligible for additional visits with Plan approval after a medical necessity review	90% after deductible**; 70% after deductible** for approved visits over Plan limits	70% of MAA after deductible**; 50% of MAA after deductible** for approved visits over Plan limits	90% after deductible**; 70% after deductible** for approved visits over Plan limits	70% of MAA after deductible**; 50% of MAA after deductible** for approved visits over Plan limits
Chiropractic therapy: Limited to 20 visits per calendar year for network and out-of-network combined	90% after deductible**;	70% of MAA after deductible**	90% after deductible**; precertification required	70% of MAA after deductible**; precertification required

* Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

** The Plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a HCSA.

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield	
	Network	***Out-of-network***
Annual deductible (network and out-of-network combined)		
Individual	$1,800 Includes prescription drug expenses	$2,800 Includes prescription drug expenses
Maximum per family (no benefits will be paid to an individual until the family deductible has been met)	$3,600 Includes prescription drug expenses	$5,600 Includes prescription drug expenses
Annual out-of-pocket maximum (includes deductible; network and out-of-network combined)		
Individual	$5,000	$7,500
*Maximum per family**	$10,000 Includes prescription drug expenses	$15,000 Includes prescription drug expenses
Lifetime maximum	None	None
Professional care (in office)		
Doctor/primary care physician (PCP) visits	80% after deductible**	70% of MAA after deductible**
Specialist visits	80% after deductible** **Aetna:** 90% after deductible for Aexcel	70% of MAA after deductible**

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield	
	Network	***Out-of-network***
Preventive care, subject to frequency limits		
Well-adult visits	100%, not subject to deductible	100% of MAA, not subject to deductible
Well-child visits	100%, not subject to deductible	100% of MAA, not subject to deductible
Adult and child immunizations	100%, not subject to deductible	100% of MAA, not subject to deductible
Routine cancer screenings (PAP test, mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible
Contraceptive devices	100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	70% of MAA after deductible**
Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	70% of MAA after deductible**
Hospital emergency room (No coverage in any medical option if not a true emergency)		
	80% after deductible**; precertification required if admitted	80% after deductible**; precertification required if admitted
Urgent care center		
	80% after deductible**	80% of MAA after deductible **Note:** For Empire BCBS coverage is 90% of billed charges (not MAA)
Hospital (inpatient and outpatient services)		
Semiprivate room and board, doctor's charges, lab, radiology, and X-ray	80% after deductible**; precertification required for hospitalization and certain outpatient procedures	70% of MAA after deductible**; precertification required for hospitalization and certain outpatient procedures
Non-routine outpatient		
Lab, radiology, and X-ray	80% after deductible**; precertification required for certain outpatient procedures	70% of MAA after deductible**; precertification required for certain outpatient procedures

	High Deductible Health Plan Administered by Aetna and Empire BlueCross BlueShield	
	Network	***Out-of-network***
Mental health and substance abuse		
Inpatient	80% after deductible**, precertification required	70% of MAA after deductible**; precertification required
Outpatient	80% after deductible**; precertification recommended	70% of MAA after deductible**; precertification recommended
Therapies		
Physical/speech/occupational therapy (all therapies combined): Limited to 60 visits a year network and out-of-network combined (30 visits a year network and out-of-network combined for the Hawaii Health Plan; separate chronic/ developmental delay benefit of 24 visits a year network and out-of-network combined for the Hawaii Health Plan); you may be eligible for additional visits with Plan approval after a medical necessity review.	80% after deductible**; 70% after deductible** for approved visits over Plan limits	70% of MAA after deductible**; 50% of MAA after deductible** for approved visits over Plan limits
Chiropractic therapy: Limited to 20 visits a year network and out-of-network combined (30 visits a year network and out-of-network combined for the Hawaii Health Plan)	80% after deductible**	70% of MAA after deductible**

* In the High Deductible Health Plan, the family out-of-pocket maximum can be satisfied as a family or by an individual within the family.

** The Plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in an HSA.

Preventive care

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

Preventive care services include but are not limited to:

> Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis and immunizations;

> Well-child services and routine pediatric care and immunizations for children, excluding travel immunizations; and

> Routine well-woman exams.

In addition to well-woman exams, the following women's preventive services are covered by network providers at 100% with no deductible to meet:

> Well-woman office visit to obtain recommended preventive services that are age- and developmentally appropriate, including preconception and prenatal care;

- Certain Food and Drug Administration (FDA)-approved contraceptive devices, including diaphragms and implantable devices, sterilization procedures, and patient education and counseling for women with reproductive capacity. See the Prescription Drug section of the SPD for information about covered contraceptive drugs. Contact your plan for details;
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period (including costs for renting breast pumps and nursing-related supplies);
- Human papillomavirus (HPV) DNA testing as part of cervical cancer screenings for women (at least every three years);
- Human immune-deficiency virus (HIV) counseling and screening for all sexually active women;
- Interpersonal and domestic violence screening and counseling;
- Counseling on sexually transmitted infections for all sexually active women; and
- Screening for gestational diabetes.

Contact the plan for details.

Patient Protection and Affordable Care Act (PPACA) Guidelines

The Patient Protection and Affordable Care Act (PPACA) requires that group health plans follow certain guidelines regarding how often certain preventive screenings should be covered. These guidelines are recommended by the U.S. Preventive Services Task Force, the Centers for Disease Control (CDC) and the Health Resources & Services Administration.

All of the Citi medical options follow these guidelines — or provide more generous benefits than what is required, however each of the plans may be administered differently. Contact your medical plan to confirm how these screenings are covered.

Screening recommendations include:

- ***Colorectal Cancer*** – covered for adults 50-75, using fecal occult blood testing, flexible sigmoidoscopy, or colonoscopy
- ***High Blood Pressure*** – covered every two years if below 120 systolic/80 diastolic, or every year if between 120-139 systolic/80-90 diastolic
- ***Lipid Disorders*** – covered for men 20-35, women 20-45 if at high risk, or men over 35, women over 45 if normal risk
- ***Type 2 Diabetes*** – covered for asymptomatic adults with blood pressure higher than $^{135}/_{80}$
- ***HIV*** – covered for adolescents and adults at increased risk and all pregnant women
- ***Syphilis*** – covered for adults at increased risk and all pregnant women
- ***Abdominal Aorta Aneurysm*** – covered one time for men 65-75 who have ever smoked
- ***Breast Cancer*** – covered every 1 to 2 years starting at 40
- ***Genetic Testing Breast and Ovarian Cancer (BRCA)*** – covered for women with family history BRCA1 or BRCA2
- ***Cervical Cancer*** – covered for sexually active women, 21-65
- ***Osteoporosis*** – covered for post menopausal women 60-85

- ***Chlamydia*** – covered for sexually active women who are under age 24 or are pregnant
- ***Gonorrhea*** – covered for sexually active women who are under age 24 or are pregnant; includes prophylactic ocular topical medical for all newborns
- ***Asymptomatic Bacteriuria*** – covered during 12-16 weeks gestation
- ***Hepatitis B*** – covered during first prenatal visit
- ***Iron Deficiency Anemia*** – covered for asymptomatic women during first prenatal visit
- ***Rh (D) Incompatibility*** – covered during prenatal visit
- ***Congenital Hypothyroidism*** – covered for newborns
- ***Phenylketonuria (PKU)*** – covered for newborns
- ***Sickle Cell Anemia (SSA)*** – covered for newborns
- ***Hearing Loss*** – covered for newborns
- ***Visual Impairment under age 5*** – covered to detect amblyopia, strabismus, and visual acuity defects.
- ***Depression*** – covered for adults when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment and follow-up; covered for adolescents age 12-18 for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive behavior or interpersonal) and follow-up
- ***Alcohol misuse*** – covered for adults, including pregnant women, in primary care setting
- ***Obesity*** – covered for adults and children age 6 and older, including intensive counseling and behavioral interventions

Preventive care guidelines for plans administered by Aetna

This section on Preventive Care describes the covered expenses for services and supplies provided when you are well.

Routine physical exams

Covered expenses include charges made by your physician for routine physical exams, including routine vision and hearing screenings given as part of the routine physical exam. A routine exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- For women, additional preventive care and screenings, not included in the above, as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration;
- Radiological services, x-rays, lab and other tests given in connection with the exam;
- Immunizations for infectious diseases and the materials for administration of immunizations that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; and
- Testing for Tuberculosis;
- For covered newborns, an initial hospital check up;
- Well visits (including routine oral screenings), for covered persons in accordance with the evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Limitations:

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams

Important Note:

For details on the frequency and age limits that apply to Routine Cancer Screenings, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.

Screening and counseling services

Covered expenses include charges made by your physician in an individual or group setting for the following:

Obesity

Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:

- Preventive counseling visits and/or risk factor reduction intervention;
- Medical nutrition therapy;
- Nutrition counseling; and
- Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits, available from Aetna. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Misuse of alcohol and/or drugs

Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Use of tobacco products

Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars; smoking tobacco; snuff; smokeless tobacco and candy-like products that contain tobacco. Coverage includes the following to aid in the cessation of the use of tobacco products:

- Preventive counseling visits;
- Treatment visits; and
- Class visits.

Benefits for the screening and counseling services above are subject to the visit maximums shown in your Schedule of Benefits. In figuring the visit maximums, each session of up to 60 minutes is equal to one visit.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams.

Family planning services

Covered expenses include charges for certain contraceptive and family planning services, even though not provided to treat an illness or injury.

Contraception services

Covered expenses include charges for certain contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive devices, including diaphragms and implantable devices, prescribed by a physician provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Other family planning

- Covered expenses include charges for family planning services, including:
  - Voluntary sterilization; and
  - Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care.

Contraception services not covered

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

Vision care services

Covered expenses include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- ***Routine*** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 12 consecutive month period.

Limitations

Coverage is subject to any applicable Calendar Year deductibles, copays and payment percentages.

Hearing exam

Covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

All covered expenses for the hearing exam are subject to any applicable deductible, copay and payment percentage.

Quick tip

Use the Health Care Spending Account (HCSA) to save money on your out-of-pocket health care expenses. Since you forfeit any money remaining in the account that you do not use by the end of the plan year, estimate conservatively.

If you enroll in coverage through the HDHP, you can use a Health Savings Account and Limited Purpose Spending Account (LPSA) to help you save. See “Health Savings Accounts (HSAs)” on page 110 for more information.

Routine cancer screenings

In the ChoicePlan 500, Oxford Health Plans PPO, and High Deductible Health Plan, cancer-screening tests are covered 100% with no deductible to meet when performed by network providers. For frequency limits, please contact your plan at the number on the back of your ID card.

Cancer screening tests are:

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

Aetna: Covered expenses include, but are not limited to, charges incurred for routine cancer screening as follows:

- mammograms;
- pap smears;

- gynecological exams;
- fecal occult blood tests;
- digital rectal exams;
- prostate specific antigen (PSA) tests;
- sigmoidoscopies;
- double contrast barium enemas (DCBE); and
- colonoscopies.

These benefits will be subject to any age; family history; and frequency guidelines as set forth in the most current:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and
- The comprehensive guidelines supported by the Health Resources and Services Administration.

Unless specified above, not covered under this benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan.

Important Note:

For details on the frequency and age limits that apply to Routine Cancer Screenings, contact your physician, log onto the Aetna website www.aetna.com, or call the number on the back of your ID card.

Using an emergency room

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

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

Urgent care

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

Genetic Information Nondiscrimination Act of 2008

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

Newborns' and Mothers' Health Protection Act notice

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

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

Women's Health and Cancer Rights Act notice

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

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

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

The Mental Health Parity and Addiction Equity Act of 2008

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

It is important to note that MHPAEA does not mandate that a plan provide MH/SUD benefits. Rather, if a plan provides medical/surgical and MH/SUD benefits, it must comply with the MHPAEA's parity provisions.

Precertification/ notification

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

Precertification requirements for Aetna plans

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

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

Infertility services

Treatment of **Infertility** must be pre-authorized by **Aetna**. Penalties apply if the treatment is received without pre-authorization. Contact the Plan for details.

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;
- A scheduled admission to a skilled-nursing hospice care or rehabilitation facility;
- Home health care, including psychiatric home care services;
- Private-duty nursing;
- Outpatient hospice care;
- Amytal interview;
- Biofeedback;
- Psychological testing;
- Electroconvulsive therapy; and
- Neurophsychological testing.

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

Mental health/chemical dependency

You must call Aetna for precertification before you obtain covered inpatient mental health and/or chemical dependency treatment, including stays in a residential treatment facility or a partial hospitalization program, outpatient detoxification, intensive outpatient programs, or psychiatric home care services.

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 112 for information about precertification requirements. Aetna will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

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

If you or your physician does not agree with Aetna’s determination, you may appeal the decision. For information about the claims appeal process, see “Claims and appeals for Aetna medical plans” on page 141.

Precertification requirements for Empire BlueCross BlueShield plans

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

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

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

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

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

You are required to obtain precertification for the following services:

- Admission to a skilled nursing facility;
- Air ambulance;
- Certain outpatient procedures;
- Gender reassignment surgeries;
- Home health care services, including private-duty nursing;
- Any infertility service;
- Inpatient facility admissions, including emergency admissions and inpatient physical rehabilitation;
- Inpatient mental health/chemical dependency;

- Organ/tissue transplants; call Empire BlueCross BlueShield before the scheduled date of any of the following:
  - The evaluation;
  - The donor search;
  - The organ procurement/tissue harvest; and
  - The transplant.

  See Organ/tissue transplants in "Covered services and supplies" on page 112 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.
- Physical, Occupational, and Speech Therapy: Visits in excess of 60 plan limit require pre-certification
- Pregnancy; call Empire's Future Moms program to ensure you receive pregnancy-related materials and the maximum benefits.
  - 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 does not agree with Empire BlueCross BlueShield's determination, you may appeal the decision. For more information about the claims appeal process, see "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 147 or call **1-866-290-9098**.

Precertification for Oxford Health Plans PPO

The following services require precertification:

- Ambulance services for inter-facility transfers
- Non-standard allergy services
- Chiropractic services;
- Dental services (accident only);
- Durable medical equipment with a retail cost of more than $1,000 whether for purchase or rental;
- Hospital and other facility admissions, including emergency admissions;
- Home health care services, including private-duty nursing;
- Infertility services;
- Reconstructive procedures;
- Hospice care;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Short-term rehabilitation (PT, OT & ST); and
- Transplant services.

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

Out-of-network services: When you receive care from an out-of-network provider, you must obtain precertification before receiving any of the listed services. (Your out-of-network provider does not obtain precertification for you.)

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 again as soon as the admission date is set. You must receive 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. If you are not able to call, have a family member contact Oxford.

Outpatient surgery/diagnostic testing/other services

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

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Infertility services, including diagnosis and treatment;
- Private-duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of $500 or more.

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

Mental health/chemical dependency

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

Organ/tissue transplants

You must obtain precertification at least fourteen 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 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 must receive a precertification request before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires precertification as a scheduled confinement.

If you or your physician does not agree with Oxford's determination, you may appeal the decision. For information about the claims appeal process, see "Claims and appeals for Oxford Health Plans medical plans" on page 151.

ChoicePlan 500

ChoicePlan 500 at a glance

Please note: For in-network covered expenses, the Plan pays a percentage of discounted rates while for out-of-network charges, the Plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

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 MAA after deductible**
Specialist visits	90% after deductible** Aetna: 95% after deductible** for Aexcel specialist	70% of MAA 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 MAA after deductible**

Type of service	Network	Out-of-network
Preventive care (subject to frequency limits)		
> Well-adult visits	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
> Well-child visits	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible
> Adult and Child Routine Immunizations	> 100%, not subject to deductible	> 70% of MAA, not subject to deductible
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	> 70% of MAA after deductible**
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	> 70% of MAA after deductible**
Routine care (subject to frequency limits)		
> Routine vision exams	> 100%, not subject to deductible, limited to one exam every 12 months	> 100% of MAA, not subject to deductible, up to $250 combined maximum *, then covered at 70% of MAA, not subject to deductible. Limited to one exam every 12 months
> Routine hearing exams	> 100%, not subject to deductible, limited to one exam every 12 months	> 100% of MAA, not subject to deductible, up to $250 combined maximum*, then covered at 70% of MAA, not subject to deductible. Limited to one exam every 12 months
Hospital (inpatient and outpatient services)		
> Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	> 90% after deductible**; precertification is required for hospitalization and certain outpatient procedures	> 70% of MAA after deductible**; precertification required for hospitalization and certain outpatient procedures
Non-routine outpatient		
> Lab, X-ray, and radiology	> 90% after deductible**; precertification is required for certain outpatient procedures	> 70% of MAA after deductible**; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 90% after deductible**	> 70% of MAA after deductible**
> Hospital delivery	> 90% after deductible** > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	> 70% of MAA after deductible** > Pre-notification 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)	> 100% after $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization, not subject to annual deductible)	> 100% after $100 copayment (waived if admitted within 24 hours, precertification required for hospitalization, not subject to annual deductible)
> Urgent care facility	> 90% after deductible**	> 90% of MAA after deductible > Note: For Empire BCBS coverage is 90% of billed charges (not MAA).
Outpatient short-term rehabilitation		
> Physical, speech, or occupational therapy. (All therapy visits are reviewed for medical necessity. PT/ST/OT therapy visits are combined with a 60-visit maximum. Additional visits over the maximum are reviewed on a case-by-case basis for medical necessity.)	> 90% after deductible** > 60 visits per year for physical, speech, developmental, and occupational therapy combined. This limit applies to network and out-of-network services combined > 70% after deductible** for visits approved for medical necessity over plan limit	> 70% of MAA 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 MAA 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 MAA after deductible**, up to 20 visits per year for network and out-of-network services combined
Other services		
> Durable medical equipment (includes orthotics/ prosthetics and appliances)	> 90% after deductible**	> 70% of MAA 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 MAA 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 MAA 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 MAA after deductible** (limited to 120 days annually for network and out-of-network services combined); precertification required
> Infertility treatment	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 90% after deductible** up to the family lifetime maximum; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 70% after deductible** up to the family lifetime maximum; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (see "Mental health/chemical dependency in and out-of-network" on page 24)		

* Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

** The Plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a HCSA.

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see “Covered services and supplies” on page 112 and “Exclusions and limitations” on page 133.

The ChoicePlan 500 is self-insured; therefore, Citi pays the claims incurred. The ChoicePlan 500 is not subject to state laws.

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

You must meet a deductible both in and out of the network before the Plan will pay benefits. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

ChoicePlan 500 network features

Deductible

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

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

The family deductible represents 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 amounts.

Coinsurance

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

Out-of-pocket maximum

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

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

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

- Charges above MAA;
- Copayments, including emergency room, office visit and urgent care;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under ChoicePlan 500.

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

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from the PCPs in the directory of network providers. You may choose a pediatrician as the PCP for your covered child. Women may also select an OB/GYN without referral from their PCP. A directory of the providers who participate in the ChoicePlan 500 network is available from the Claims Administrator. You may call or visit the Claims Administrator's website:

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

Specialists

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

Aetna Aexcel specialists

Aexcel is a designation within Aetna's network that includes specialists who have demonstrated effectiveness in the delivery of care based on defined 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, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, MA, ME, MI, MO, NJ, NV, NY, OH, OK, PA, TX, VA, and WA.

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

Allergist

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

Preventive care

Preventive care services are covered at 100%, no deductible to meet for the ChoicePlan 500. For additional information on what is considered to be preventive care, see "Preventive care" on page 64.

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 Claims Administrator;
- Routine diagnostic tests. For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care; and
- Routine well-woman exams.

In addition, ChoicePlan 500 will cover both cancer-screening tests and well-adult and well-child immunizations performed by network providers at 100%, not subject to deductible. Routine 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.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- American Medical Association;
- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine care

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

- Routine vision exam:
  - **Network:** Covered at 100%, not subject to deductible; one exam every 12 months, performed by a network ophthalmologist or optometrist;
  - **Out-of-network:** Covered at 100%, not subject to deductible up to $250 per calendar year*, then covered at 70% of MAA, not subject to deductible; limited to one exam every 12 months.

* Combined maximum with well-adult and well-child visits, routine cancer screenings and routine hearing

Aetna: covered expenses include a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.

- Routine hearing exam:
  - **Network:** Covered at 100%, not subject to deductible; one exam every 12 months, performed by a network provider.
  - **Out-of-Network:** Covered at 100%, not subject to deductible up to $250 per calendar year*, then covered at 70% of MAA, not subject to deductible; limited to one exam every 12 months.

Aetna: covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) received through a preferred provider is covered at 90% for covered services after the deductible has been met. Services provided by a network physician in an out-of-network hospital are covered at the network benefit level.

Note: Any charges submitted by an out-of-network hospital would be treated as out-of-network claims. Precertification of an inpatient admission is required. Precertification is also required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit and then the plan pays 100% (not subject to annual deductible). If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.

- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

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

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna's online provider directory at www.aetna.com. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Empire BCBS: Empire uses actual charges billed, not MAA, when determining plan payment for an out-of-network provider.

Charges not covered

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

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

For information about how to file a claim or appeal a denied claim, see "Claims and appeals for Aetna medical plans" on page 141 or "Claims and appeals for Empire BlueCross BlueShield medical plans" on page 147.

Paying your bill at your network doctor's office

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

Choosing network providers

ChoicePlan 500 is administered by Aetna and Empire BlueCross BlueShield. When you enroll in ChoicePlan 500, you may request a provider directory that lists doctors and other providers who belong to the network.

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

- Empire BlueCross BlueShield: **www.empireblue.com/citi**; to access a network provider through the BlueCross BlueShield Association BlueCard ® PPO Program, select “Find a Doctor,” and then choose “Across the Country (National Provider Search).” Enter your search details (provider name, provider specialty, search location,). Enter your identification prefix (which is the first three letters of your member ID located on your ID card). If you do not have your member ID card handy, select your State and your plan, PPO and click on “Search.” You will have a variety of search options to help you find a provider who meets your needs. You may also call **1-866-290-9098**.

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

Out-of-network features

You can use an out-of-network provider for medical services and still be reimbursed under ChoicePlan 500. These expenses generally are reimbursed at a lower level than network expenses, after you have met the out-of-network deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see “Claims and appeals for Aetna medical plans” on page 141, or “Claims and appeals for Empire BlueCross BlueShield medical plans” on page 147.

Deductible and coinsurance

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

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

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

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

Once you have met the deductible, ChoicePlan 500 normally pays 70% of maximum allowed amount (MAA) for covered expenses that are received out-of-network.

Out-of-pocket maximum

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

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

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

- Expenses that exceed MAA;
- Emergency room copayment;
- Penalties;
- Prescription drug expenses; and
- Charges for services not covered under the Plan.

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

Preventive care

Each participant has a $250 annual credit toward all out-of-network wellness services. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of MAA. 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 Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care; and
- Routine well-woman exams.

Routine care

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

- **Routine vision exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network ophthalmologist or optometrist; and
- **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of MAA, 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). Precertification of an inpatient admission is required. Precertification is required for certain outpatient procedures and services.

Emergency care

The emergency room copayment is $100 per visit and then the Plan pays 100% (not subject to annual deductible). If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived.

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.

- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

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

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your I.D. card, or you may access Aetna's online provider directory at www.aetna.com. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Multiple surgical procedure guidelines

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

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

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

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

Mental health/chemical dependency in and out-of-network

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

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

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

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

Coverage levels

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

Mental health benefits include, but are not limited to:

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

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

Aetna: In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider; and
- The treatment plan is for a condition that can favorably be changed.
- Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

Inpatient services

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

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

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

Aetna: Benefits are payable for charges incurred in a hospital, psychiatric hospital, or residential treatment facility. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

Covered expenses also include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient services

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

Aetna: Covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Emergency care

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

Medically necessary

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

For more information about what your Plan covers, see "Covered services and supplies" on page 112. You may also contact your Plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent review and discharge planning

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

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

Empire BlueCross BlueShield uses medical management guidelines developed by Milliman, a third party organization, when determining these medical management services.

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

The Oxford Health Plans Preferred Provider Organization (PPO) is administered by Oxford Health Plans and is available in the Connecticut, New Jersey, and New York tri-state area. The Oxford Health Plans PPO is self-insured; therefore, Citi pays the claims incurred. The Oxford Health Plans PPO is not subject to state laws.

Under the Plans, you have the freedom to choose your doctor or health care facility when you need health care. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the Plan and whether you choose a preferred provider or a non-preferred provider. Using preferred (network) providers saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the maximum allowed amounts (MAA). Second, the level of reimbursement for many services is higher when using preferred providers. For a list of providers, visit the Oxford website at **www.oxhp.com** or call Oxford Member Services at **1-800-760-4566** (if you are not currently participating in the Plans) or **1-800-396-1909** (if you are currently participating in the Plans).

The Oxford Health Plans PPO at a glance

Please note: For in-network covered expenses, the Plan pays a percentage of discounted rates while for out-of-network charges, the Plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

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 MAA after deductible**
> Specialist visits	> 90% after deductible**	> 70% of MAA 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 MAA after deductible**
Preventive care (subject to frequency limits)		
> Well-adult visits	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum*, then covered at 70% of MAA, not subject to deductible
> Well-child visits	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum*, then covered at 70% of MAA, not subject to deductible
> Adult and Child Routine Immunizations	> 100%, not subject to deductible	> 70% of MAA, not subject to deductible

Type of service	Network	Out-of-network
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum*, then covered at 70% of MAA, not subject to deductible
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	> 70% of MAA after deductible**
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	> 70% of MAA after deductible**
Routine care (subject to frequency limits)		
> Routine vision exams – In- and out-of-network combined limit: one exam every 12 months	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum*, then covered at 70% of MAA, not subject to deductible
> Routine hearing exams – In- and out-of-network combined limit: one exam every 12 months	> 100%, not subject to deductible	> 100%, not subject to deductible, up to $250 maximum*, then covered at 70% of MAA, not subject to deductible
Hospital inpatient and outpatient		
> Semiprivate room and board, doctor's charges, radiology, lab, X-ray, and surgical care	> 90% after deductible**; precertification required for hospitalization and certain outpatient procedures	> 70% of MAA after deductible**; precertification required for hospitalization and certain outpatient procedures
Non-routine outpatient		
> Radiology, lab, and X-ray	> 100%, not subject to deductible; precertification is required for certain outpatient procedures	> 70% of MAA after deductible**; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 90% after deductible**	> 70% of MAA after deductible**
> Hospital delivery	> 90% after deductible** > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery	> 70% of MAA after deductible** > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery
Emergency care (no coverage if not a true emergency)		
> Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	> 100% after $100 copayment (waived if admitted within 24 hours; precertification required for hospitalization; not subject to deductible)	> 100% after $100 copayment (waived if admitted within 24 hours; precertification required for hospitalization; not subject to deductible)
> Urgent care facility	> 90% after deductible**	> 90% of MAA after deductible**

Type of service	Network	Out-of-network
Outpatient short-term rehabilitation		
> Physical, speech, or occupational therapy	> 90% after deductible** > 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out-of-network services combined > 70% after deductible** for visits approved for medical necessity over Plan limits	> 70% of MAA 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 MAA after deductible** for visits approved for medical necessity over Plan limits
> Chiropractic therapy	> 90% after deductible**, up to 20 visits per year for network and out-of-network services combined; precertification required	> 70% of MAA after deductible**, up to 20 visits per year for network and out-of-network services combined; precertification required
Other services		
> Durable medical equipment (includes orthotics/prosthetics and appliances)	> 90% after deductible**	> 70% of MAA 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 MAA 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 MAA 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 MAA after deductible** (limited to 120 days annually for network and out-of-network services combined); precertification required
> Infertility treatments	> 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; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 70% after deductible** up to the family lifetime maximum; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (refer to "Mental health/chemical dependency: in and out-of-network" on page 31)		

* Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing, and routine vision. The maximum is measured on a calendar year basis.

** The Plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a HCSA.

These tables are intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see "Covered services and supplies" on page 112 and "Exclusions and limitations" on page 133.

How the Plan Works

Network coverage

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

Deductible

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

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

The family deductible represents 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 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 amounts

Coinsurance

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

Out-of-pocket maximum

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

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

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

> Prescription drug expenses; and

> Charges for services not covered under the Oxford PPO

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 do not cross-accumulate.

Primary care physician (PCP)

When seeking primary care services, you should choose a provider from primary care physicians in the directory of network providers. You may choose a pediatrician as a PCP for your covered child. Women may also select an OB/GYN without a referral from their PCP. A directory of the network providers who participate in the Oxford PPO is available from the Claims Administrator. You may call or visit the Claims Administrator's website at **www.oxhp.com** or **1-800-760-4566** (if you are not currently participating in the Plans) or **1-800-396-1909** (if you are currently participating in the Plans).

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

Specialists

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

Allergist

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

Preventive care

Preventive care services are covered at 100%, not subject to deductible. The Plan pays Benefits for Preventive care services provided on an outpatient basis at a Physician's office, an Alternate Facility or a Hospital.

Preventive care services encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and include the following as required under applicable law:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
- Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, such additional preventive care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For more specific information regarding what is concerned to be Preventive Care, see "Preventive care" on page 64.

Routine care

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

- **Routine vision exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network ophthalmologist or optometrist; and
- **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam every 12 months, performed by a network otolaryngologist or otologist.

Infertility

Treatment of infertility must be pre-authorized. Penalties apply if the treatment is received without pre-authorization. Contact the Plan for details.

Emergency care

The emergency room copayment is $100 per visit. If you are admitted to the hospital within 24 hours of the emergency room visit for any condition, the copayment is waived and 90% after deductible.

Charges not covered

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

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

For information about how to file a claim or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 151.

Out-of-network coverage

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

For information about how to file a claim for out-of-network services or appeal a denied claim, see “Claims and appeals for Oxford Health Plans medical plans” on page 151.

Deductible and coinsurance

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

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

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

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

Once you have met the deductible, Oxford PPO normally pays 70% of maximum allowed amount (MAA) charges for covered expenses that are received out-of-network.

Out-of-pocket maximum

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

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

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

- Expenses that exceed MAA;
- Prescription drug expenses; and
- Charges for services not covered under the Plan.

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

Preventive care

Each participant has a $250 annual credit toward all out-of-network wellness services. Thereafter, covered expenses are not subject to the deductible and expenses that exceed the $250 credit are covered at 70% of MAA. 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 Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child services and routine pediatric care;
- Routine well-woman exams;
- Routine cancer screenings;
- Routine vision exams; and
- Routine hearing exams.

In addition, the Oxford PPO will cover well adult and well child routine immunizations performed by out-of-network providers. Well adult and well child routine immunizations are covered 70% of MAA, with no deductible to meet.

Infertility

Treatment of infertility must be pre-authorized. Penalties apply if the treatment is received without pre-authorization. Contact the Plan for details.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of MAA, 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 $100 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

Urgent care

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

Mental health/chemical dependency: in and out-of-network

The Oxford PPO 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 find the right provider for you. In an emergency, the intake coordinator will also provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

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

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

Coverage levels

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

Mental health benefits include, but are not limited to:

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

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

Inpatient services

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

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

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

Outpatient services

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

Emergency care

Emergency care for mental health or chemical dependency treatment does not require a referral. However you are required to call the Oxford PPO within 48 hours after an emergency admission. The Oxford PPO behavioral health providers are available 24/7 to accept calls.

Medically necessary

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

For more information about what your Plan covers, see "Covered services and supplies" on page 112. You may also contact the 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 PPO requires certification of any confinement, services, supplies, procedures, or treatments:

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

Fully insured health maintenance organizations (HMOs)

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

This section provides a description of the medical benefit information available to HMO participants and should be read together with the *Eligibility and participation* section, the *Administrative information* section, and the HMO Certificate of Insurance listed under "2013 insured HMOs". There is a separate HMO Certificate of Insurance for each fully insured HMO.

- *Eligibility and participation* and *Administrative information* provide information about eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.
- HMO Certificates of Insurance provide detailed information about the benefits and coverage available through each HMO. For example, the Certificate of Insurance will generally provide you with information concerning:
  - The nature of services provided to members, including all benefits and limitations;
  - Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the HMO) and circumstances under which services may be denied; and
  - The procedures to be followed when obtaining services and the procedures available for the review of claims for services that are denied in whole or in part.

The HMO will send a Certificate of Insurance and a provider directory to you at your home upon enrollment in the HMO. If you do not receive your Certificate of Insurance, call your HMO at the telephone number listed under “2013 insured HMOs” or on your ID card.

For a list of the HMOs offered by Citi and the Certificate of Insurance for each HMO, see “2013 insured HMOs”. The HMOs available to you will depend on your home zip code.

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

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

If you have questions about coverage, providers, or using an HMO, call the HMO directly at the telephone number listed under “2013 insured HMOs”. This number can also be found on your HMO ID card, if you are a member of that HMO.

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

Typical plan design features of an HMO offered by Citi

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) from the list of providers before obtaining any medical services. You may also choose a pediatrician as the PCP for your child. Women may also select an OB/GYN without a referral from their PCP.

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

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

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

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

As a reminder, benefits vary depending on the HMO.

For more information, review the Certificate of Insurance or call your HMO.

If you have questions or concerns about specific covered services, call the HMO in which you are enrolled directly. Visit “2013 insured HMOs” on page 100 for information HMO contact information.

Primary care physician (PCPs)

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

Many HMOs will require each covered family member to select a PCP. You will find PCPs listed in the HMO’s provider directory, which are listed under “2013 insured HMOs”. Generally, if you do not choose a PCP, one will be selected for you until you select one.

Your options for choosing a PCP depend on the HMO you select. For instance, your PCP could be a general practitioner, an internist, or a family practitioner. You may choose a pediatrician as your child's PCP. In addition to choosing a PCP for other health care needs, women may select a gynecologist without a referral from their PCP for their routine gynecological checkups.

Specialists

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

If your HMO requires a referral and you visit a specialist without one, you may be responsible for the full cost of your care. Generally, you cannot request referrals after you have received the care, except in emergencies. You should contact the HMO directly or see 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 vision exams; and
- Routine hearing exams.

Hospital care

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

See the HMO Certificate of Insurance listed under "2013 insured HMOs" for more information about hospital coverage.

Maternity care

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

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

The 48/96-hour minimum stay after childbirth is required by federal law. State laws may provide additional requirements for maternity coverage. See the HMO Certificate of Insurance listed under "2013 insured HMOs" for more information about maternity coverage.

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

Emergency care

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

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

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

See the HMO Certificate of Insurance "2013 insured HMOs" for more information, including your HMO's definition of a true medical emergency.

Benefit limits

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

2013 insured HMOs

The following fully insured HMOs are offered by Citi for 2012 in each state. The inclusion of an HMO in a state list does not mean that the option is available throughout the state. Your eligibility to participate in one of the HMOs offered is based on your home zip code. You can determine whether the HMO is available where you live by contacting the HMO.

To view the Certificate of Insurance, please click on the HMO plan name in the chart below. For more information on plan coverage details, contact your HMO.

HMO	Contact information
Coventry Health Care of Iowa	> 1-800-257-4692 > www.chciowa.com
Geisinger Health Plan (Pennsylvania)	> 1-800-447-4000 > 1-800-631-1656 (annual enrollment information) > www.thehealthplan.com
Health Plan Hawaii Plus (HMSA)	> 1-808-948-6372 > 1-808-948-5060 (annual enrollment information) > www.hmsa.com
SelectHealth (Utah and part of Idaho)	> 1-800-538-5038 > www.selecthealth.org
Independent Health (upstate New York)	> 1-800-501-3439 > 1-800-453-1910 (annual enrollment information) > www.independenthealth.com
Kaiser FHP of California - Northern	> 1-800-464-4000 > http://my.kp.org/citigroup
Kaiser FHP of California - Southern	> 1-800-464-4000 > http://my.kp.org/citigroup
Kaiser FHP of Colorado	> 1-800-632-9700 > http://my.kp.org/citigroup
Kaiser FHP of Georgia	> 1-888-865-5813 > http://my.kp.org/citigroup

HMO	Contact information
Kaiser FHP of Hawaii	> 1-808-432-5955 > 1-800-966-5955 (annual enrollment information) > http://my.kp.org/citigroup
Kaiser FHP of the Mid-Atlantic States	> 1-301-468-6000 > 1-800-777-7902 (annual enrollment information) > http://my.kp.org/citigroup
Presbyterian Health Plan (New Mexico)	> 1-800-356-2219 > www.phs.org
Sanford Health Plan (South Dakota, North Dakota, parts of Minnesota and parts of Iowa)	> 1-800-752-5863 > www.sanfordhealthplan.com

High Deductible Health Plan

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

> The HDHP provides what is referred to as “catastrophic” medical coverage. It is *not* intended for individuals who want to be reimbursed for almost all their health care expenses.

> The HDHP is designed to be used in conjunction with a Health Savings Account (HSA) in which you contribute before-tax dollars to pay for your deductible and other eligible out-of-pocket expenses. HDHP participants are permitted to enroll in the Limited Purpose Health Care Spending Account (LPSA). Participants cannot enroll in the Health Care Spending Account (HCSA). *Enrollment in an HCSA during the plan year disqualifies participants from making HSA contributions.* This includes any credits contributed to an HCSA by Citi on your behalf.

> If you had an HCSA prior to a qualified change in status (for example, if an HCSA was established for you due to excess Live Well Rewards), then you are permitted to retain the HCSA, even if you elect an HDHP. However, the establishment of the HCSA precludes you from being eligible for the HSA for the remainder of the plan year.

> Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.

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

The HDHP is self-insured; therefore, Citi pays the claims. The plan is not subject to state laws.

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

High Deductible Health Plan at a glance

Please note: For in-network covered expenses, the Plan pays a percentage of discounted rates while for out-of-network charges, the Plan pays a percentage of the maximum allowed amount (MAA). See the Glossary for a definition of MAA, which is sometimes referred to as "Recognized Charges."

Type of service	Network	Out-of-network
Annual deductible (includes prescription drug expenses)		
> Single	> $1,800	> $2,800
> Family	> $3,600	> $5,600
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 visits	> 80% after deductible**	> 70% of MAA after deductible**
> Specialist visits	> 80% after deductible** > Aetna: 90% after deductible** for Aexcel	> 70% of MAA after deductible**
> Allergy treatment	> 80% after deductible**	> 70% of MAA after deductible**
Preventive care (subject to frequency limits)		
> Well-adult visits and routine immunizations	> 100%, not subject to deductible	> 100% of MAA, not subject to deductible
> Well-child visits and routine immunizations		
> Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)		
> Contraceptive devices	> 100%, not subject to deductible, for diaphragms and Mirena, an implantable device. All other implantable devices will be covered at 90% after deductible**	> 70% of MAA after deductible**
> Voluntary sterilization – including tubal ligation, sterilization implants and surgical sterilizations	> 100%, not subject to deductible. Male sterilization services (e.g., vasectomies) are covered at 90% after deductible**	> 70% of MAA after deductible**
Routine care (subject to frequency limits)		
> Routine vision exam	> 100%, not subject to deductible; limit one exam every 12 months	> 100% of MAA, not subject to deductible; limit one exam every 12 months
> Routine hearing exam	> 100%, not subject to deductible; limit one exam every 12 months	> 100% of MAA, not subject to deductible; limit one exam every 12 months
Hospital inpatient and outpatient		
> Semiprivate room and board, doctor's charges, lab, X-ray, radiology, and surgical care	> 80% after deductible**; precertification required for hospitalization and certain outpatient procedures and services	> 70% of MAA after deductible**; precertification required for hospitalization and certain outpatient procedures and services

Type of service	Network	Out-of-network
Non-routine outpatient		
> Lab, X-ray, and radiology	> 80% after deductible**; precertification is required for certain outpatient procedures	> 70% of MAA after deductible**; precertification is required for certain outpatient procedures
Maternity care		
> Physician office visit	> 80% after deductible**	> 70% of MAA after deductible**
> Hospital delivery	> 80% after deductible**	> 70% of MAA after deductible**
Emergency care (no coverage if not a true emergency)		
> Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)	> 80% after deductible**; precertification required if admitted	> 80% after deductible**; precertification required if admitted
> Urgent care facility	> 80% after deductible**	> 80% of MAA after deductible** > Note: for Empire Blue Cross Blue Shield coverage is 80% of billed charges (not MAA).
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 Plan limits	> 70% after deductible** > 60 visits per year for physical, speech, developmental, and occupational therapy > 50% of MAA after deductible** for visits approved for medical necessity above Plan limits
Other services		
> 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. > 80% after deductible**; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family	> Covered up to a $24,000 family lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 70% after deductible**; precertification required > Prescriptions covered through Express Scripts up to a $7,500 lifetime pharmacy maximum per family
Prescription drugs (see the *Prescription Drugs* section)		
Mental health and chemical dependency (see "Mental health/chemical dependency" on page 40)		

* The family deductible, as well as the family out-of-pocket maximum, can be satisfied as a family or by an individual within the family.

** The Plan will pay this percentage of the cost after you first pay the full deductible of the plan. The deductible can be paid with after-tax dollars, such as cash or check, or with before-tax dollars if you have available funds in a HSA.

High Deductible Health Plan features

- Most covered network expenses are reimbursed at 80% of negotiated charges after the annual deductible has been met. Claims submitted by an out-of-network provider generally are reimbursed at 70% of maximum allowed amount (MAA) after the deductible has been met. **Note:** Only your deductible and coinsurance — not the amount billed by the doctor/facility — is applied to your out-of-pocket maximum.
- Routine physical exams for adults and children and well-woman exams are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet.
- Cancer screenings are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet. Cancer screening tests are the Pap smear, mammography, sigmoidoscopy, colonoscopy, and PSA test.
- Other recommended preventive care services are covered at 100% when using network providers and 100% of MAA when using out-of-network providers with no deductible to meet.
- Prescription drugs are covered by the Citigroup Prescription Drug Program administered by Express Scripts. You first must meet your combined medical and prescription drug deductible before you can purchase prescription drugs at a retail network pharmacy and through the Express Scripts Home Delivery program for the Plan's copayment or coinsurance, except as described in the bullet immediately following.
- You can purchase certain preventive care medications for a copayment or coinsurance *before* the deductible is met. Copayments/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the Express Scripts' website. If you are a participant in a medical plan with prescription drug coverage through Express Scripts, visit **www.express-scripts.com**. If not, visit **https://member.express-scripts.com/preview/citigroup2013**.
- The Plan has no lifetime maximum benefit other than for infertility coverage.

Citi has determined that the HDHP does constitute "creditable coverage" under Medicare. For information on creditable coverage, see the Creditable Coverage Disclosure Notice.

How the Plan works

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

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

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

- Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POSII Open Access Plan or call **1-800-545-5862**
- Empire BlueCross BlueShield: **www.empireblue.com/citi**; select the PPO or call **1-866-290-9098**

Deductible and coinsurance

You must meet an annual deductible of $1,800 for individual (employee only) coverage or $3,600 for family (two or more in a family) before the Plan 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 met each calendar year before any benefits will be paid.

Other than for services not subject to the deductible, any one or a combination of family members must meet the full family deductible before the Plan pays any benefits. There is no individual limit within the family deductible limit. The deductible can be met as follows:

- **Network**
  - **Employee only:** The individual deductible of $1,800 applies.
  - **Two or more in a family:** The $3,600 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Once you have met the deductible, the Plan normally pays 80% of the negotiated rate for covered health services if you or your covered dependent uses a network hospital/provider.
- **Out-of-Network**
  - **Employee only:** The individual deductible of $2,800 applies.
  - **Two or more in a family:** The $5,600 family deductible applies, one or a combination of all family members must meet the full family deductible before the Plan pays any benefits.
  - **Note:** Expenses are normally reimbursed at 70% of MAA for claims for covered services submitted for an out-of-network provider.

Out-of-pocket maximum

Your out-of-pocket maximum is $5,000 individual/$10,000 family (out-of-network $7,500/individual and $15,000/family). The amount includes the $1,800/individual and $3,600/family (out-of-network $2,800/$5,600) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Only your deductible and coinsurance amount – not the amount billed over MAA by your doctor or facility – is applied to your out-of-pocket maximum. The maximum can be met as follows:

- **Employee only**: $5,000 (out-of-network $7,500)
- **Two or more in a family:** The $10,000 (out-of-network $15,000) family out-of-pocket maximum applies. There is no individual out-of-pocket maximum within the family out-of-pocket maximum. Eligible expenses can be combined to meet the family out-of-pocket maximum, which means that one or a combination of all family members must meet the full family out-of-pocket maximum

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

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

- Expenses that exceed MAA,
- Charges for services not covered under the Plan, and
- Any expense that would have been reimbursed if you had followed the notification requirements for care.

Preventive care

Covered expenses are not subject to the deductible and are covered at 100% when using network providers or 100% of MAA 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 Claims Administrator;
- Routine diagnostic tests: For example, CBC (complete blood count), cholesterol blood test, urinalysis; and
- Routine well-woman exams.

In addition, the Plan 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.

Preventive care services covered in the network at 100% will be reviewed annually and updated prospectively to comply with recommendations of the:

- United States Preventive Care Task Force;
- Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention; and
- Comprehensive Guidelines Supported by the Health Resources and Services Administration.

For more information on what is considered preventive care, see "Preventive care" on page 64.

Routine care

Routine health screenings are covered at:

- 100%, not subject to deductible; and
- 100% of the MAA, not subject to 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 12 months; and
  - **Aetna**: covered expenses include a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam.
- **Routine hearing exam:** Limited to one exam per 12 months.

Aetna: covered expenses include charges for an audiometric hearing exam if the exam is performed by:

- A physician certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

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

Hospital

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

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

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

Aetna: Precertification requirements apply to both inpatient care and partial hospitalizations.

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at 80% for care received from both network and out-of-network providers.

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

Aetna: When emergency care is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.
- If you seek care in an emergency room for a non-emergency condition, the plan will not cover the expenses you incur.

Urgent care

Urgent care centers will be reimbursed at:

- 80% of the negotiated rate (after the deductible is met) for care received from a network provider; or
- 80% of MAA (after the deductible is met) for care received from an out-of-network provider

Aetna: Call your PCP if you think you need urgent care. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician. If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your

I.D. card, or you may access Aetna's online provider directory at www.aetna.com. Follow-up care is not considered an emergency or urgent condition and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

Empire BCBS: Empire uses actual charges billed, not MAA, when determining plan payment for an out of network provider.

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 defined 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, CA, CO, CT, DC, DE, FL, GA, IL, IN, KS, KY, MD, MA, ME, MI, MO, NJ, NV, NY, OH, OK, PA, TX, VA, and WA.

When you visit an Aexcel specialist you do not need a referral. The Plan will pay 90% of covered expenses after your deductible for Aexcel specialists. To find an Aexcel specialist visit, **www.aetna.com/docfind**; select the Aetna Standard Plans, Aetna Select, and look for the providers listed with the blue star. This blue star identifies the Aexcel specialists.

Mental health/chemical dependency

The Aetna/Empire BlueCross Blue Shield HDHP provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

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

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

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

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 HDHP.

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.

Aetna: In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a written treatment plan supervised by a physician or licensed provider; and
- The treatment plan is for a condition that can favorably be changed.

Benefits are payable for charges incurred in a hospital, psychiatric hospital, residential treatment facility or behavioral health provider's office.

Inpatient services

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

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

Aetna: Benefits are payable for charges incurred in a hospital, psychiatric hospital, or residential treatment facility. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting. Covered expenses also include charges made for partial confinement treatment provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a mental disorder. Such benefits are payable if your condition requires services that are only available in a partial confinement treatment setting.

Outpatient services

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

Aetna: covered expenses include charges for treatment received while not confined as a full-time inpatient in a hospital, psychiatric hospital or residential treatment facility. The plan covers partial hospitalization services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility.

Emergency care

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

Medically necessary

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

For more information about what your Plan covers, see "Covered services and supplies" on page 112. 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)

A Health Savings Account (HSA) is used in conjunction with a qualified High Deductible Health Plan (HDHP).

When you enroll in the HDHP, you are eligible to open an HSA through any bank or institution that offers one. HSAs were designed to work with HDHP to help you:

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

To establish an HSA, you must:

- Be covered under the High Deductible Health Plan (HDHP);
- Have no other health coverage except what is permitted under "other health coverage";
- Not be enrolled in Medicare part A & B or Medicaid; and
- Not be claimed as a dependent on someone else's tax return.

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

Citi will contribute to your accounts if:

- You enroll in the HDHP for 2013;
- Open a Citi HSA administered by ConnectYourCare;
- Accept the terms of an HSA through Your Benefits Resources™; and
- Satisfy Citi's policies and procedures required to establish an HSA.

The annual contribution amounts are based on your medical plan coverage category. Amounts paid are up to $500 for Employee Only coverage and up to $1,000 for any other coverage category. Citi's contribution is paid on a quarterly basis.

Details of the deadlines to receive Citi's contribution to your HSA are below:

Deadline to receive Citi's contribution		Employee Only	Employee + Spouse/ Children/Family
Q1	4:00 p.m. EST on 12/31/11	$125	$250
Q2	4:00 p.m. EST on 3/31/12	$125	$250
Q3	4:00 p.m. EST on 6/30/12	$125	$250
Q4	4:00 p.m. EST on 9/30/12	$125	$250

The maximums that can be contributed to an HSA for 2013 are:

- $3,250 for an eligible individual with employee only coverage and
- $6,450 for an eligible individual enrolling in any other coverage category.

Under federal law, individuals who are 55 or older by December 31, 2012, can make a catch-up contribution of an additional $1,000 for 2013 and each year going forward.

If you do not enroll in the HDHP, by law you cannot establish a HSA.

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

Health Savings Account features

- You "own" your HSA; your account is portable.
- Contributions to an HSA can be made by individuals, employers, or both.
- Contributions (subject to limits) can be changed at any time as long as you continue to be enrolled in a qualified High Deductible Health Plan (HDHP)
- Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.
- Withdrawals (to pay for qualified medical expenses, as determined by the IRS) are tax-free under federal and many state income tax laws.
- You do not forfeit funds that you do not use by year-end. Instead, HSA funds remaining in your account will roll over to the following year.
- However, you will pay a penalty of 20% of the disbursed amount for disbursements that are not used for qualified medical expenses, or medical expenses for dependents not considered as tax dependents under Section 152 of the Internal Revenue Code

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

The HSA and the LPSA

If you enroll in the HDHP and make tax-free contributions to an HSA you cannot participate in a HCSA. *HCSA enrollment is considered "impermissible medical care coverage" and disqualifies your contributions to an HSA. This includes any credits contributed to a HCSA by Citi on your behalf.*

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

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

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

Covered services and supplies

This list of covered services and supplies applies to all ChoicePlan 500, High Deductible Health Plan, and Oxford PPO medical 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 maximum allowed amount (MAA) or, for network services, the negotiated rates of the Plan.

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

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

Acupuncture

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

Adult immunizations

The following are the guidelines for covered adult immunizations:

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

Ambulatory surgical center

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

Anesthetics

Drugs that produce loss of feeling or sensation either generally or locally, except when done for dental care not covered by the Plan. When administered as part of a medical procedure, anesthesia must be administered by a board-certified anesthesiologist. Anesthesia is not covered when rendered in the doctor's office or when administered by the operating surgeon, unless it is administered by a dentist for dental care that is covered by the Plan.

Note: The Oxford PPO will cover this service when medically necessary and appropriate.

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 including vasectomy, tubal ligation, sterilization implants and surgical sterilizations;
- Injectables such as Depo-Provera; and
- Surgical implants for contraception, such as Mirena or Norplant.

Dietitian/nutritionist

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

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

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

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

Foot care

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

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

Hearing aids

Hearing aids are covered, regardless of the reason for hearing loss.

- **Adults:** Once every 36 months.
- **Children:** Every 24 months.

Home health care (combined with private-duty nursing)

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

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

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

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage limited to expenses for the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate or if it is the only room type available);
- Other services and supplies;
- Part-time nursing care by or supervised by a RN or LPN;
- Home health care services as shown under home health care; the limit on the number of visits shown under home health care does not apply to hospice patients;
- Counseling for the patient and covered dependents;
- Pain management and symptom control; and
- Bereavement counseling for covered dependents; services must be given within six months after the patient's death, and covered services are limited to a total of 15 visits for each family member.
  - For **Aetna ChoicePlan 500, Empire BlueCross BlueShield ChoicePlan 500, and Oxford Health Plans**, bereavement counseling is covered under the mental health benefit.

Bereavement counseling must be provided 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; and
  - Preoperative care and post-operative care:
    - Administration and processing of blood;
    - Anesthesia and anesthesia services;

- Oxygen and oxygen therapy;
- Inpatient physical and rehabilitative therapy, including cardiac and pulmonary rehabilitation;
- X-rays, laboratory tests, and diagnostic services; and
- Magnetic resonance imaging (MRI).

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

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

Infertility treatment

Empire BlueCross Blue Shield and Oxford Health Plans PPO:

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

Precertification for all infertility services is strongly recommended. Penalties may apply if the treatment is received without precertification. 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 participants.
> Advanced reproductive services:
  - Ovulation induction cycle with menotropins;
  - Harvesting of Plan participant's eggs;
  - Artificial insemination;
  - Infertility surgery (diagnostic or therapeutic);

- ART services and treatment, including in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and cryopreserved embryo transfer and Frozen Embryo Transfer (FET);

> Medical expenses for infertility treatment are covered up to a family lifetime maximum of $24,000. Only expenses for advanced services (e.g., IVF, GIFT, ZIFT) and comprehensive services (e.g., artificial insemination) accumulate towards the lifetime maximum. Expenses for diagnosis and treatment of the underlying medical condition do not count towards the lifetime maximum.

> Prescription drug expenses associated with infertility treatment are covered up to a lifetime maximum of $7,500, through the *Prescription Drugs* section.

> Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs.

Aetna:

Treatment of infertility must be pre-authorized. Penalties apply if the treatment is received without pre-authorization.

Basic Infertility Expenses

Covered expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility. These expenses do not count towards the medical lifetime maximum.

Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered as an employee, or be a covered dependent who is the employee's spouse (same- or opposite-sex)/domestic partner/civil union partner.

Even though not incurred for treatment of an illness or injury, covered expenses will include expenses incurred by an eligible covered female for infertility if all of the following tests are met:

> A condition that is a demonstrated cause of infertility which has been recognized by a gynecologist, or an infertility specialist, and your physician who diagnosed you as infertile, and it has been documented in your medical records.

> The procedures are done while not confined in a hospital or any other facility as an inpatient.

> Your FSH levels are less than, 19 miU on day 3 of the menstrual cycle.

> The infertility is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.

> A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this Plan.

Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist upon pre-authorization by Aetna, subject to all the exclusions and limitations.

> Ovulation induction with menotropins is subject to the maximum benefit and

> Intrauterine insemination is subject to the maximum benefit.

Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);
- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

ART services for procedures that are covered expenses.

Eligibility for ART Benefits

To be eligible for ART benefits, you must meet the requirements above and:

- Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your physician to Aetna's infertility case management unit;
- Obtain pre-authorization from Aetna's infertility case management unit for ART services by an ART specialist.

Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the Exclusions and Limitations

- Subject to the maximum benefit of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by Aetna or any affiliated company of Aetna) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection ("ICSI"); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under the plan

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

Laboratory tests/X-rays

X-rays or tests for diagnosis or treatment.

Licensed counselor services

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

Medical care

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

Medical supplies

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

Medical transportation services

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

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

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

Morbid obesity expenses (non-HMO/PPO plans)

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

Dietician/nutritionist coverage is also available for morbid obesity. See "Dietitian/nutritionist" on page 113.

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; and
  - Cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is covered only when not done in connection with the removal, replacement, or repair of teeth; and
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement
- If oral surgery/dental services are needed in connection with an accident or injury
  - **Aetna** requires that any treatment must be completed in the calendar year of the accident or in the next calendar year unless postponed due to a patient's physical condition.
- If crowns, dentures, bridges, or in-mouth appliances are installed due to injury, covered expenses only include charges for:
  - The first denture or fixed bridgework to replace lost teeth;
  - The first crown needed to repair each damaged tooth; and
  - An in-mouth appliance used in the first course of orthodontic treatment after the injury.
  - Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.
- **Empire BlueCross BlueShield** accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:
  - Extraction of impacted wisdom teeth;
  - Services to treat an injury to sound natural teeth that are given within 12 months of accident/injury;
  - TMJ surgery; and
  - Anesthesia for dental services only when the dental service itself is covered, is administered by an anesthesiologist and is done outside of the doctor's office.

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

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

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.

Oxford Health Plans accepts the following oral surgeries as medical in nature and covered under the medical plan as necessary:

- Extraction of impacted wisdom teeth;
- Services to treat an injury to sound natural teeth; and
- TMJ surgery.
- **Note:** Oxford does not cover General Dental Care. Coverage is available for the following limited dental and oral surgical procedures:
  - Oral surgery for the repair of sound natural teeth, jaw bones, or surrounding tissue which is related to accidental injury.
  - Treatment for tumors or cysts requiring pathological examinations of the jaw, cheek, lip, tongue, or roof or floor of the mouth.
  - TMJ Surgery is covered. All surgery must be precertified in advance through Oxford's Medical Management Department.
- Care may be accessed on either an In-Plan or Out-of-Plan basis. Pre-certification is required.

Organ/tissue transplants

Your Claims Administrator must be notified before the scheduled date (or as soon as reasonably possible) of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.
- **Empire BlueCross BlueShield** and **Aetna** do not require precertification within a certain number of days, but **Oxford** requires precertification within at least 14 days.

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.
  - **Aetna** covers donor search fees through the National Marrow Donor Program.

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; and
- Other transplant procedures when your Claims Administrator determines that they are medically necessary to perform the procedure as a designated transplant.

For **Aetna**, transplant services are covered as long as the transplant is not experimental or investigational and has been approved in advance. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna's network of providers for transplants and transplant-related services, including evaluations and follow-up care. Each facility has been selected to perform only certain types of transplants, based on its quality of care and successful clinical outcomes.

For **Aetna** plans (ChoicePlan 500 and High Deductible Health Plan), a transplant will be covered as a network service only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered a non-participating facility for transplant-related services, even if the facility is considered a participating facility for other types of services.

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

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

Transplants performed at participating, non-BDCT facilities are covered at 90% with access to the travel and lodging benefit; all other facilities are covered at 70% with no access to the travel and lodging benefit.

Medical care and treatment

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

- Pretransplant evaluation for one of the procedures listed above;
- Organ acquisition and procurement;
- Hospital and physician fees;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant;
- 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. **Note**: Coverage of donor costs is generally limited to medically necessary procedures, inpatient confinement (e.g., semi-private room and board in an acute hospital setting) and a postoperative global period not to exceed 180 calendar days. (This maximum applies to the **Oxford PPO**. It does not apply to the **Aetna and Empire BlueCross BlueShield** plans); and
- Transportation and lodging.

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

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging for the patient (while not confined) and one companion. Benefits are paid at a per-diem rate of $50 for one person or $100 a day for two people (a maximum of $50 per person — $100 for patient and companion combined — per night is paid toward lodging expenses; meals are not covered);
- Travel and lodging expenses are available only if the transplant recipient resides more than:
  - 100 miles from the designated transplant facility for **Aetna** plans;
  - **Empire BlueCross BlueShield** plans do not have a mileage requirement.
- If the patient is a covered dependent minor child, the transportation expenses of two companions will be covered; lodging expenses will be reimbursed at the $100 per-diem rate;
- A combined overall lifetime maximum of $10,000 per covered person for all transportation and lodging expenses incurred by the transplant recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the Plan in connection with all transplant procedures. (For **Aetna** plans, a $10,000 maximum [per occurrence] will apply to all non-health benefits in connection with any one type of procedure. These benefits are available until one year following the date of the procedure.)

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

- There may be some differences in coverage for transportation and lodging.

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

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

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

For more information, contact your Claims Administrator directly.

Orthoptic training

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

Outpatient occupational therapy

See “Rehabilitation therapy” on page 124.

Outpatient physical therapy

See “Rehabilitation therapy” on page 124.

Prescribed drugs

Prescribed drugs and medicines for inpatient services.

Preventive care

Covered expenses include:

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

A $250 calendar year maximum applies to out-of-network services per covered family member.

For more specific information regarding what is concerned to be Preventive Care, see “Preventive care” on page 64.

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

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

- **Aetna ChoicePlan 500 and Empire BlueCross BlueShield ChoicePlan 500:** A combined network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered. Precertification is required. Additional visits may be covered if approved in advance by your Plan.
- **Oxford Health Plans PPO:** Private-duty nursing services are covered as medically necessary. A combined network and out-of-network maximum benefit of 200 visits per calendar year (combined with home health care visits) applies. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered.

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; and
  - 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;

- Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to one of the following:
  - Surgery, radiation therapy, or other treatment that affects the vocal chords;
  - Cerebral thrombosis (cerebral vascular accident);
  - Brain damage due to accidental injury or organic brain lesion (aphasia);
  - Accidental injury that happens while the person is covered under the Plan;
  - Chronic conditions (such as cerebral palsy or multiple sclerosis); or
  - Developmental delay.

Inpatient

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

Outpatient

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

Routine Care

Covered expenses include:

- Vision exam once every 12 months; and
- Hearing exam once every 12 months.

A $250 calendar year maximum applies to out-of-network services per covered family member.

Skilled nursing facility services

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

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

Speech therapy

See “Rehabilitation therapy” on page 124.

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 PPO:** All surgical procedures must be precertified in advance.)

Reconstructive surgery

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

Assistant-surgeon services

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

Multiple surgical procedure guidelines

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

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

- First procedure: The Plan will allow 100% of the negotiated or maximum allowed amount (MAA).
- Second procedure: The Plan will allow 50% of the negotiated or MAA.
- Third and additional procedures: The Plan will allow 50% of the negotiated or MAA for each additional procedure.

- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or MAA for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or MAA for tertiary/additional procedures.

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

Transsexual surgery, sex change, or transformation

The plan does cover procedures, treatments and related services designed to alter a participant's physical characteristics from his or her biologically determined sex to those of another sex.

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.

Transgender benefits

Transgender benefits are covered under the Citi health plans. The way the coverage is administered varies slightly between the carriers. This section describes specific coverage details for each of the carriers.

Aetna: Aetna considers sex reassignment surgery medically necessary when all of the following criteria are met:

- Member is at least 18 years old; *and*
- Member has met criteria for the diagnosis of "true" transsexualism, including:
  - A sense of estrangement from one's own body, so that any evidence of one's own biological sex is regarded as repugnant; *and*
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals and to live in society as a member of the other sex for at least 2 years, that is, not limited to periods of stress; *and*
  - Absence of physical inter-sex of genetic abnormality; *and*
  - Does not gain sexual arousal from cross-dressing; *and*
  - Life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood; *and*
  - Not due to another biological, chromosomal or associated psychiatric disorder, such as schizophrenia; *and*
  - Wishes to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- Member has completed a recognized program of transgender identity treatment as evidenced by all of the following:
  - A qualified mental health professional* who has been acquainted with the member for at least 18 months recommends sex reassignment surgery documented in the form of a written comprehensive evaluation; *and*
  - For genital surgical sex reassignment, a second concurring recommendation by another qualified mental health professional * must be documented in the form of a written expert opinion**; *and*
  - For genital surgical sex reassignment, member has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract, since genital

surgical sex reassignment includes the invasion of, and the alteration of, the genitourinary tract (urological examination is not required for persons not undergoing genital reassignment); *and*

- Member has demonstrated an understanding of the proposed male-to-female or female-to-male sex reassignment surgery with its attendant costs, required lengths of hospitalization, likely complications, and post surgical rehabilitation requirements of the planned surgery; *and*
- Psychotherapy is not an absolute requirement for surgery unless the mental health professional's initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months); *and*
- For genital surgical sex reassignment, the member has successfully lived and worked within the desired gender role full-time for at least 12 months (so-called real-life experience), without periods of returning to the original gender; *and*
- For genital surgical sex reassignment, member has received at least 12 months of continuous hormonal sex reassignment therapy recommended by a mental health professional and carried out by an endocrinologist (which can be simultaneous with the real-life experience), unless medically contraindicated.

* At least one of the two clinical behavioral scientists making the favorable recommendation for surgical (genital) sex reassignment must possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.). Note: Evaluation of candidacy for sex reassignment surgery by a mental health professional is covered under the member's medical benefit, unless the services of a mental health professional are necessary to evaluate and treat a mental health problem, in which case the mental health professional's services are covered under the member's behavioral health benefit. Please check benefit plan descriptions.

** Either two separate letters or one letter with two signatures is acceptable.

Medically necessary core surgical procedures for female to male persons include: mastectomy, hysterectomy, vaginectomy, salpingo-oophorectomy, metoidioplasty, phalloplasty, urethroplasty, scrotoplasty and placement of testicular prostheses, and erectile prostheses.

Medically necessary core surgical procedures for male to female persons include: penectomy, orchidectomy, vaginoplasty, clitoroplasty, and labiaplasty.

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

> Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;

> Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

Empire BlueCross BlueShield: Gender reassignment surgery* is considered medically necessary when the *all* of the following criteria are met:

> The patient is at least 18 years of age; and

> The patient has been diagnosed with the Gender Identity Disorder (GID) of transsexualism, including all of the following:

- The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
- The transsexual identity has been present persistently for at least two years; and
- The disorder is not a symptom of another mental disorder or a chromosomal abnormality; and
- The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and

> For those patients without a medical contraindication, the patient has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and

> The patient has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, with no returning to their original gender, including one or more of the following:

- Maintain part- or full-time employment; or
- Function as a student in an academic setting; or
- Function in a community-based volunteer activity; and

> The patient has acquired a legal gender-identity-appropriate name change; and

> The patient has provided documentation to the treating therapist that persons other than the treating therapist know that the patient functions in the desired gender role; and

> Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and

> Demonstrable knowledge of the required length of hospitalizations, likely complications, and post surgical rehabilitation requirements of various surgical approaches; and

> Demonstrable progress in consolidating one's gender identity, including demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health (this implies satisfactory control of problems such as sociopathy, substance abuse, psychosis, suicidality, for instance); and

> A letter** from the patient's physician or mental health provider, who has treated the patient for a minimum of 18 months, documenting the following:

- The patient's general identifying characteristics; and
- The initial and evolving gender, sexual, and other psychiatric diagnoses; and
- The duration of their professional relationship including the type of psychotherapy or evaluation that the patient underwent; and
- The eligibility criteria that have been met and the physician or mental health professional's rationale for surgery; and
- The degree to which the patient has followed the eligibility criteria to date and the likelihood of future compliance; and
- Whether the author of the report is part of a gender identity disorder treatment team; and

> A letter** from a second physician or mental health provider familiar with the patient's treatment and the psychological aspects of Gender Identity Disorders, corroborating the information provided in the first letter (see #10 above); and

- When one of the signatories on the letters indicated above is not the treating surgeon, a letter from the surgeon confirming that they have personally communicated with the treating mental health provider or physician, as well as the patient, and confirming that the patient meets the above criteria, understands the ramifications and possible complications of surgery, and that the surgeon feels that the patient is likely to benefit from surgery.

Gender reassignment surgery may include any of the following procedures:

- *Male-to-Female Procedures*
  - Orchiectomy
  - Penectomy
  - Vaginoplasty
  - Clitoroplasty
  - Labiaplasty
- *Female-to-Male Procedures*
  - Hysterectomy
  - Salpingo-oophorectomy
  - Vaginectomy
  - Metoidioplasty
  - Scrotoplasty
  - Urethroplasty
  - Placement of testicular prostheses
  - Phalloplasty

At least one of the professionals submitting a letter must have a doctoral degree (Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the doctoral degree specifications, in addition to the specifications set forth above.

Not Medically Necessary:

Gender reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

Cosmetic and Not Medically Necessary:

The following surgeries are considered cosmetic and not medically necessary when used to improve the gender specific appearance of a patient who has undergone or is planning to undergo gender reassignment surgery:

- Reduction thyroid chondroplasty
- Liposuction
- Rhinoplasty
- Facial bone reconstruction
- Face lift
- Blepharoplasty
- Voice modification surgery
- Hair removal/hairplasty
- Breast augmentation

Oxford Health Plans PPO: Covered services include:

- Psychotherapy for gender identity disorders and associated co-morbid psychiatric diagnoses;
- Continuous hormone replacement
  - Hormones of the desired gender;
  - Hormones injected by a medical provider (for example during an office visit) are covered by the medical plan. Benefits for these injections vary depending on the plan design.
  - Oral and self-injected hormones from a pharmacy are not covered under the medical plan. Refer to the Outpatient Prescription Drug Rider, or SPD for self funded plans, for specific prescription drug product coverage and exclusion terms.
- Genital Surgery (by various techniques which must be appropriate to each patient), including:
  - Complete hysterectomy
  - Orchiectomy
  - Penectomy
  - Vaginoplasty
  - Vaginectomy
  - Clitoroplasty
  - Labiaplasty
  - Salpingo-oophorectomy
  - Metoidioplasty
  - Scrotoplasty
  - Urethroplasty
  - Placement of testicular prosthesis
  - Phalloplasty
- Surgery to change specified secondary sex characteristics, specifically:
  - thyroid chondroplasty (removal of the Adam's Apple); and
  - bilateral mastectomy; and
  - augmentation mammoplasty (including breast prosthesis if necessary) if the Physician prescribing hormones and the surgeon have documented that breast enlargement after undergoing hormone treatment for 18 months is not sufficient for comfort in the social role;
- Laboratory testing to monitor the safety of continuous hormone therapy.

Hormone Replacement:

The Covered Person must meet all of the following eligibility qualifications for hormone replacement (in addition to the plan's overall eligibility requirements as shown in the plan document).

- Age 18 years or older for hormones to change physical characteristics; and
- Demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; and
- The Covered Person must meet the definition of Gender Identity Disorder (see definition below); and
- Initial hormone therapy must be preceded by:
  - a documented real-life experience (living as the other gender) of at least three months prior to the administration of hormones; or
  - a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

Genital surgery and surgery to change secondary sex characteristics eligibility qualifications:

The Covered Person must meet all of the following eligibility qualifications for genital surgery and surgery to change secondary sex characteristics (in addition to the plan's overall eligibility requirements as shown in the plan document):

- The surgery must be performed by a qualified provider at a facility with a history of treating individuals with gender identity disorder;
- The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards*;
- The Covered Person must be age 18 years or older for irreversible surgical interventions;
- The Covered Person must complete 12 months of continuous hormone therapy for those without contraindications;
- The Covered Person must complete 12 months of successful continuous full time real life experience in the desired gender;
- The Covered Person must meet the definition of Gender Identity Disorder (see definition below); and
- The Covered Person's Physician who is performing the surgery must follow the Notification process prior to performing the surgery.

Exclusions:

The following treatments are not covered:

- Reversal of genital surgery or reversal of surgery to revise secondary sex characteristics.
- Sperm preservation in advance of hormone treatment or gender surgery.
- Cryopreservation of fertilized embryos.
- Voice modification surgery.
- Facial feminization surgery, including but not limited to: facial bone reduction, face "lift", facial hair removal, and certain facial plastic reconstruction.
- Suction-assisted lipoplasty of the waist.
- Rhinoplasty (except if rhinoplasty criteria is met. See the Rhinoplasty, Septoplasty, and Repair of Vestibular Stenosis Coverage Determination Guideline.)

- Blepharoplasty (except if blepharoplasty criteria is met. See the Blepharoplasty, Blepharoptosis and Brow Ptosis Repair Coverage Determination Guideline.)
- Surgical or hormone treatment on enrollees under 18 years of age.
- Surgical treatment not prior authorized by Oxford.
- Drugs for hair loss or growth.
- Drugs for sexual performance or cosmetic purposes (except for hormone therapy described above.
- Voice therapy.
- Services that exceed the maximum dollar limit on the plan.
- Transportation, meals, lodging or similar expenses.

Treatment centers

- Room and board; and
- Other services and supplies.

Voluntary sterilization

- Vasectomy; and
- Tubal ligation.

Reversals are not covered.

Well-child care

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

Exclusions and limitations

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

- Acupuncture, accupressure, and acupuncture therapy, except as described under “Covered services and supplies” on page 112;
  - **Oxford:** Acupuncture care is available on an in and out of network basis. There are no maximum payment or visit limitations.
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
  - **Aetna:** Any charges in excess of the benefit, dollar, day, visit or supply limits unless specified otherwise. This includes charges for a service or supply furnished by a network provider in excess of the negotiated charge, and charges for a service or supply furnished by an out-of-network provider in excess of the maximum allowed amount or recognized charge. Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan are excluded. Charges submitted for services by an unlicensed hospital, physician, or other provider or not within the scope of the provider’s license are excluded;
  - Aetna: Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs.
- Any service in connection with, or required by, a procedure or benefit not covered by the Plan;

- Any services or supplies that are not medically necessary, as determined by the Claims Administrator;
- BEAM (brain electrical activity mapping) neurologic testing;
  - **OXFORD:** Oxford will provide coverage for magnetoencephalography and magnetic source imaging as outlined in the guidelines below.
    - Magnetoencephalography and magnetic source imaging (MEG/MSI) **are considered to be medically necessary** for presurgical evaluation in patients with intractable focal epilepsy and presurgical evaluation of brain tumors and vascular malformations
    - Magnetoencephalography and magnetic source imaging (MEG/MSI) **are not considered to be medically necessary** for the evaluation of brain function in patients with trauma, stroke, learning disorders, or other neurologic disorders and psychiatric conditions such as schizophrenia.
  - There is insufficient evidence to conclude that the use of MEG/MSI improves health outcomes such as improved diagnostic accuracy and treatment planning for patients with trauma, stroke, learning disorders, or other neurologic disorders and psychiatric conditions. Further clinical trials demonstrating the clinical usefulness of this procedure are necessary before it can be considered proven to have a benefit on health outcomes for these conditions.
- Biofeedback, except as specifically approved by the Claims Administrator;
- Blood, blood plasma, synthetic blood, or other blood derivatives or substitutes, and the provision of blood, other than blood derived clotting factors, except as described under “Covered services and supplies” on page 112. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Claims Administrator;
- Charges for canceled office visits or missed appointments; boutique, access, or concierge fees to doctors;
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments.
- 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, or injured persons, or pregnant women. 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;
- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments;

- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, salabrasion, chemosurgery, and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or that are performed as a treatment for acne. However, the Plan covers reconstructive surgery as described under "Covered services and supplies" on page 112;
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for Aetna, Empire BlueCross BlueShield, or United HealthCare);
- 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; or
  - 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 of injuries or diseases to the mouth, teeth, gums, or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, and non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment. See "Covered services and supplies" on page 112 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, including impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use) problems and learning disabilities are not covered by the Plan; See "Covered services and supplies" on page 112 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, under the Plan for the same services;
- Experimental, investigational, or unproven services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by the Claims Administrator, unless approved by the Claims Administrator in advance. This exclusion will not apply to drugs:
  - That have been granted investigational new drug (IND) treatment or Group treatment IND status;
  - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;
  - That the Claims Administrator has determined, based on scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. See the "Glossary" for the definition of experimental, investigational or unproven services;
- Eyeglasses and contact lenses (**Empire BlueCross BlueShield and Oxford** will cover eyeglasses or contact lenses within 12 months following cataract surgery);
- False teeth;
- **Aetna**: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth;
- Hair analysis;
- Hair transplants, hair weaving, or any drug used in connection with baldness. Wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation therapy. Wigs and hairpieces needed for endocrine, metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and preauthorized by the Claims Administrator;
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated;
- **Aetna**: Hearing services or supplies that do not meet professionally accepted standards; hearing exams given during a stay in a hospital or other facility; replacement parts or repairs for a hearing aid; and any tests, appliance, and devices for the improvement of hearing or to enhance other forms of communication to compensate for hearing loss or devices that stimulate speech, except as described under "Covered services and supplies" on page 112;
- Herbal medicine, holistic, or homeopathic care, including drugs;
  - **Aetna:** Not covered; however, discounts are available through the Aetna Natural Products and Services Discount Program;
  - **Empire BlueCross BlueShield:** Not covered; however, discounts on alternative medicine and treatment are available through the Empire SpecialOffers Program. Visit Empire's website at **www.empireblue.com/citi** for information about the Empire SpecialOffers Program;
  - **Oxford:** Not covered; however, discounts are available for some services under the Oxford Healthy Bonus Program;

- Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, equipment or supplies to aid sleeping or sitting, removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, figerglass, dust, pet dander, pests or other sources of allergies or illness are not covered. Improvements to your home or place of work, including, but not limited to, ramps, elevators, handrails, stair glides, and swimming pools, are not covered;
- Hypnotherapy, except when approved in advance by the Claims Administrator;
- Implantable drugs (other than contraceptive implants);
- Infertility services, except as described under "Covered services and supplies" on page 112. The Plan does not cover charges for the freezing and storage of cryopreserved embryos and charges for storage of sperm or surrogate mothers or any charges associated with them.
- Aetna's exclusions and limitations on infertility services includes:
  - **Infertility** services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
  - Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
  - Reversal of sterilization surgery;
  - **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
  - The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
  - Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
  - Home ovulation prediction kits;
  - Drugs related to the treatment of non-covered benefits;
  - Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
  - Any services or supplies provided without pre-authorization from Aetna's infertility case management unit;
  - **Infertility** Services that are not reasonably likely to result in success;
  - Ovulation induction and intrauterine insemination services if you are not **infertile**.
- Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be preauthorized by the Claims Administrator
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs; (**Oxford Health Plans** offers a $200 reimbursement every six months for employees who can prove they have had 50 gym visits in that time period and $100 every six months for spouses who can prove they have had 50 gym visits in that time period).

- Naturopathy;
- Nutritional counseling and nutritionists except as described under “Covered services and supplies” on page 112;
- 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 garments, support hose, bedpans, splints, braces, compresses, reagent strips and other devices not intended for reuse by another patient; contact your plan for details. (These may not always be excluded.);
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services;
- Physical, psychiatric, or psychological exams, testing, or treatments not otherwise covered, when such services are:
  - For purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
  - Relating to judicial or administrative proceedings or orders;
  - Conducted for purposes of medical research; or
  - To obtain or maintain a license of any type;
- Radial keratotomy or any other related procedures designed to surgically correct refractive errors, such as LASIK, PRK, or ALK;
- Recreational, educational, and sleep therapy, including any related diagnostic testing;
  - **Oxford:** Covered when medically necessary
- Religious, marital, family, career, social adjustment, pastoral, financial, and sex counseling, including related services and treatment;
- Reversal of voluntary sterilizations, including related follow-up care;
- Routine hand and foot care services, including routine reduction of nails, calluses, and corns;
- Services not covered by the Plan;
- Services or supplies covered by any automobile insurance policy, up to the policy’s amount of coverage limitation;
- Services provided by your close relative (your spouse, child, brother, sister, or your or your spouse’s parent or grandparent) for which, in the absence of coverage, no charge would be made;
- Services given by volunteers or persons who do not normally charge for their services;
- Services required by a third party including, but not limited to, physical exams and diagnostic services in connection with:
  - Obtaining or continuing employment;
  - Obtaining or maintaining any license issued by a municipality, state, or federal government;
  - Securing insurance coverage;
  - Travel; and
  - School admissions or attendance, including exams required to participate in athletics unless the service is considered to be part of an appropriate schedule of wellness services;

- Services you are not legally obligated to pay for in the absence of this coverage;
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the Plan and is undergoing a covered transplant. Services for, or related to, transplants involving mechanical or animal organs are not covered;
- Special education, including lessons in sign language to instruct a Plan participant whose ability to speak has been lost or impaired to function without that ability;
- Special medical reports, including those not directly related to the medical treatment of a Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation;
- Specific non-standard allergy services and supplies, including, but not limited to:
  - Skin titration (Rinkle method);
  - Cytotoxicity testing (Bryan's Test);
  - Treatment of non-specific candida sensitivity;
  - Urine autoinjections;
- Stand-by services: Boutique, concierge, or on-call fees required by a physician;
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by the Claims Administrator;
- Telephone consultations;
- Therapy or rehabilitation including, but not limited to:
  - Primal therapy;
  - Chelation therapy (except to treat heavy metal poisoning);
  - Rolfing;
  - Psychodrama;
  - Recreational;
  - Deep Sleep therapy;
  - Thermograms and thermography;
  - Megavitamin therapy;
  - Purging;
  - Bioenergetic therapy;
  - Vision perception training, except when medically necessary; and
  - Carbon dioxide therapy;
- Thermograms and thermography;
- 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 or an 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/nutritional supplements, liquid diets, diet plans, or any related products. **Aetna**: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition

Additional medical plan information

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

Mental health and substance abuse benefits

All visits for both inpatient and outpatient mental health and substance abuse treatment are reimbursed at the same coinsurance level as other medical services, according to your Plan, subject to medical necessity.

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

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

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

Programs available to medical plan participants

Some medical plans offer special programs and services for plan participants. To find out about these programs and services, contact your plan for details.

Claims and appeals

Claims and appeals for Aetna medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service. The amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

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

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

Contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option.

The form explains how and when to file a claim.

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

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

Appeals for Aetna medical plans

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claims, Appeals and External Review section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company (Aetna). The notice will explain the reason for the denial and the appeal procedures available under the Plan.

Urgent Care Claims

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

Ongoing Course of Treatment

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of

the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Health Claims – Standard Appeals

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is **experimental or investigational**; or
- A decision that the service or supply is not **medically necessary**.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Aetna) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under §502(a) of ERISA or under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.

This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

Aetna will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of Aetna), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action under Section 502(a) of ERISA, if applicable.

Health Claims – Voluntary Appeals

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from Aetna will describe the process to follow if you wish to pursue an External Review, and will include a copy of the *Request for External Review Form*.

You must submit the *Request for External Review Form* to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, Aetna must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, Aetna must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and Aetna must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

Aetna will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

- Your medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;
- The terms of your Plan to ensure that the ERO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;
- Any applicable clinical review criteria developed and used by Aetna, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and
- The opinion of the ERO's clinical reviewer or reviewers after considering the information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

- A Final Internal Adverse Benefit Determination, if you have a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

Immediately upon receipt of the request for expedited External Review, Aetna will determine whether the request meets the reviewability requirements set forth above for standard External Review. Aetna must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, Aetna will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

Claims and appeals for Empire BlueCross BlueShield medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service.

For purposes of these Appeal provisions, “claim for benefits” means a request for benefits under the plan. The term includes both pre-service and post-service claims.

- A pre-service claim is a claim for benefits under the plan for which you have not received the benefit or for which you may need to obtain approval in advance.
- A post-service claim is any other claim for benefits under the plan for which you have received the service.

If your claim is denied or if your coverage is rescinded:

- You will be provided with a written notice of the denial or rescission; and
- You are entitled to a full and fair review of the denial or rescission.

The procedure the Claims Administrator will follow will satisfy the requirements for a full and fair review under applicable federal regulations.

Notice of adverse benefit determination

If your claim is denied, the Claims Administrator’s notice of the adverse benefit determination (denial) will include:

- Information sufficient to identify the claim involved
- The specific reason(s) for the denial;
- A reference to the specific plan provision(s) on which the claims administrator’s determination is based;
- A description of any additional material or information needed to perfect your claim;
- An explanation of why the additional material or information is needed;
- A description of the plan’s review procedures and the time limits that apply to them, including a statement of your right to bring a civil action under ERISA if you appeal and the claim denial is upheld;

- Information about any internal rule, guideline, protocol, or other similar criterion relied upon in making the claim determination and about your right to request a copy of it free of charge, along with a discussion of the claims denial decision; and
- Information about the scientific or clinical judgment for any determination based on medical necessity or experimental treatment, or about your right to request this explanation free of charge, along with a discussion of the claims denial decision.
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman who may assist you.

For claims involving urgent/concurrent care:

- The Claims Administrator's notice will also include a description of the applicable urgent/concurrent review process; and
- The Claims Administrator may notify you or your authorized representative within 72 hours orally and then furnish a written notification.

Appeals

You have the right to appeal an adverse benefit determination (claim denial or rescission of coverage). You or your authorized representative must file your appeal within 180 calendar days after you are notified of the denial or rescission. You will have the opportunity to submit written comments, documents, records, and other information supporting your claim. The Claims Administrator's review of your claim will take into account all information you submit, regardless of whether it was submitted or considered in the initial benefit determination.

- The Claims Administrator shall offer a single mandatory level of appeal and an additional voluntary second level of appeal which may be a panel review, independent review, or other process consistent with the entity reviewing the appeal. The time frame allowed for the Claims Administrator to complete its review is dependent upon the type of review involved (e.g. pre-service, concurrent, post-service, urgent, etc.).

For pre-service claims involving urgent/concurrent care, you may obtain an expedited appeal. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To file an appeal for a claim involving urgent/concurrent care, you or your authorized representative must contact the Claims Administrator at (the number shown on your identification card) and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider's name
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for appeals should be submitted in writing by the *Member* or the *Member's authorized representative*, except where the acceptance of oral *appeals* is otherwise required by the nature of the *appeal* (e.g. urgent care). You or your authorized representative must submit a request for review to:

Empire BCBS
PO Box 5072
Middletown, NY 10940-5072

Upon request, the Claims Administrator will provide, without charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim. "Relevant" means that the document, record, or other information:

- Was relied on in making the benefit determination; or
- Was submitted, considered, or produced in the course of making the benefit determination; or
- Demonstrates compliance with processes and safeguards to ensure that claim determinations are made in accordance with the terms of the plan, applied consistently for similarly-situated claimants; or
- Is a statement of the plan's policy or guidance about the treatment or benefit relative to your diagnosis.

The Claims Administrator will also provide you, free of charge, with any new or additional evidence considered, relied upon, or generated in connection with your claim. In addition, before you receive an adverse benefit determination on review based on a new or additional rationale, the Claims Administrator will provide you, free of charge, with the rationale.

How your appeal will be decided

When the Claims Administrator considers your appeal, the Claims Administrator will not rely upon the initial benefit determination or, for voluntary second-level appeals, to the earlier appeal determination. The review will be conducted by an appropriate reviewer who did not make the initial determination and who does not work for the person who made the initial determination. A voluntary second-level review will be conducted by an appropriate reviewer who did not make the initial determination or the first-level appeal determination and who does not work for the person who made the initial determination or first-level appeal determination.

If the denial was based in whole or in part on a medical judgment, including whether the treatment is experimental, investigational, or not medically necessary, the reviewer will consult with a health care professional who has the appropriate training and experience in the medical field involved in making the judgment. This health care professional will not be one who was consulted in making an earlier determination or who works for one who was consulted in making an earlier determination.

Notification of the outcome of the appeal

If you appeal a claim involving urgent/concurrent care, the Claims Administrator will notify you of the outcome of the appeal as soon as possible, but not later than 72 hours after receipt of your request for appeal.

If you appeal any other pre-service claim, the Claims Administrator will notify you of the outcome of the appeal within 30 days after receipt of your request for appeal

If you appeal a post-service claim, the Claims Administrator will notify you of the outcome of the appeal within 60 days after receipt of your request for appeal.

Appeal denial

If your appeal is denied, that denial will be considered an adverse benefit determination. The notification from the Claims Administrator will include all of the information set forth in the above section entitled "Notice of Adverse Benefit Determination."

Voluntary second level appeals

If you are dissatisfied with the Plan's mandatory first level appeal decision, a voluntary second level appeal may be available. If you would like to initiate a second level appeal, please write to the address listed above. Voluntary appeals must be submitted within 60 calendar days of the denial of the first level appeal. You are not required to complete a voluntary second level appeal prior to submitting a request for an independent External Review.

External review

If the outcome of the mandatory first level appeal is adverse to you and it was based on medical judgment, you may be eligible for an independent External Review pursuant to federal law.

You must submit your request for External Review to the Claims Administrator within four (4) months of the notice of your final internal adverse determination.

A request for an External Review must be in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. You do not have to re-send the information that you submitted for internal appeal. However, you are encouraged to submit any additional information that you think is important for review.

For pre-service claims involving urgent/concurrent care, you may proceed with an Expedited External Review without filing an internal appeal or while simultaneously pursuing an expedited appeal through our internal appeal process. You or your authorized representative may request it orally or in writing. All necessary information, including the Claims Administrator's decision, can be sent between the Claims Administrator and you by telephone, facsimile or other similar method. To proceed with an Expedited External Review, you or your authorized representative must contact the Claims Administrator at (the number shown on your identification card) and provide at least the following information:

- The identity of the claimant;
- The date (s) of the medical service;
- The specific medical condition or symptom;
- The provider's name
- The service or supply for which approval of benefits was sought; and
- Any reasons why the appeal should be processed on a more expedited basis.

All other requests for External Review should be submitted in writing unless the Claims Administrator determines that it is not reasonable to require a written statement. Such requests should be submitted by you or your authorized representative to:

Empire BCBS
PO Box 5072
Middletown, NY 10940-5072

This is not an additional step that you must take in order to fulfill your appeal procedure obligations described above. Your decision to seek External Review will not affect your rights to any other benefits under this health care plan. There is no charge for you to initiate an independent External Review. The External Review decision is final and binding on all parties except for any relief available through applicable state laws or ERISA.

Requirement to file an appeal before filing a lawsuit

No lawsuit or legal action of any kind related to a benefit decision may be filed by you in a court of law or in any other forum, unless it is commenced within three years of the Plan's final decision on the claim or other request for benefits. If the Plan decides an appeal is untimely, the Plan's latest decision on the merits of the

underlying claim or benefit request is the final decision date. You must exhaust the Plan's internal Appeals Procedure but not including any voluntary level of appeal, before filing a lawsuit or taking other legal action of any kind against the Plan. If your health benefit plan is sponsored by your employer and subject to the Employee Retirement Income Security Act of 1974 (ERISA) and your appeal as described above results in an adverse benefit determination, you have a right to bring a civil action under Section 502(a) of ERISA.

Claims and appeals for Oxford Health Plans medical plans

All claims for benefits must be filed within certain time limits. Medical claims must be filed within two years of the date of service.

Network benefits

In general, if you receive Covered Services from a Network provider, Oxford will pay the Physician or facility directly. If a Network provider bills you for any Covered Service other than your Copay or Coinsurance, please contact the provider or call the Customer Service phone number on your ID card for assistance.

Keep in mind, you are responsible for meeting the Annual Deductible and paying any Copay or Coinsurance owed to a Network provider at the time of service, or when you receive a bill from the provider.

If you receive Covered Services from a Network Provider but not in accordance with the terms and conditions of this SPD, coverage will be provided as described in this SPD. When you see a Network Provider under these circumstances, the Covered Services will be treated as if they were delivered by a non-Network Provider, and you must file a claim as described below.

Out-of-network benefits

If you receive a bill for Covered Services from a non-Network provider, you (or the provider if they prefer) must send the bill to Oxford for processing. To make sure the claim is processed promptly and accurately, a completed claim form must be attached and mailed to Oxford at the address on the back of your ID card.

How to submit a claim

You can obtain a claim form by visiting **oxfordhealthplans.com**, calling the toll-free Customer Service number on your ID card or contacting your Plan Administrator. If you do not have a claim form, simply attach a brief letter of explanation to the bill, and verify that the bill contains the information listed below. If any of these items are missing from the bill, you can include them in your letter:

- Your name and address;
- The patient's name, age and relationship to the Participant;
- The number as shown on your ID card;
- The name, address and tax identification number of the provider of the service(s);
- A diagnosis from the Physician;
- The date of service;
- An itemized bill from the provider that includes:
  - the Current Procedural Terminology (CPT) codes;
  - a description of, and the charge for, each service;
  - the date the Sickness or Injury began; and
  - A statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage, you must include the name and address of the other carrier(s).

Failure to provide all the information listed above may delay any reimbursement that may be due you.

The above information should be filed with us at the address on your ID card. When filing a claim for outpatient Prescription Drug Benefits, submit your claim to the pharmacy benefit manager claims address noted on your ID card.

Payment Options

When you receive Covered Services from a non-Network Provider, the Plan will reimburse you and you will then be responsible for reimbursing the Provider. You may not assign the right to reimbursement under this SPD to a non-Network Provider without Oxford's consent. However, in Oxford's discretion, the Plan may pay a non-Network Provider directly.

Limitations

All requests for reimbursement must be made within 90 days of the date Covered Services were rendered. Failure to request reimbursement within the required time will not invalidate or reduce any claim if it was not reasonably possible to provide such proof within the 90-day period. However, such request must be made as soon as reasonably possible thereafter. Under no circumstances will the Plan be liable for a claim that is submitted more than six months after the date services were rendered, unless you are legally incapacitated and unable to submit the request. All reimbursements to non-Network Providers are subject to UCR unless you were referred to a non-Network Provider by your PCP or Oxford.

If you receive a bill from a network provider

The cost of Covered Services provided by Network Providers in accordance with the terms of this SPD will be billed directly to Oxford. No claim forms are necessary.

If you should receive a bill from a Network Provider for Covered Services, please contact the Customer Service Department immediately.

Claim information

Please allow up to 30 business days for the processing of Network claims. Claims for non-Network Covered Services will be paid within 60 business days after Oxford receives proof of the claim.

If necessary, Oxford's Claims Department will contact you for more information regarding your claim in order to speed up the processing. If you would like to inquire about the status of a claim, call the "Claims" telephone number list in the front of this SPD. Please have the date of service and your ID number ready.

Explanation of Benefits (EOB)

You may request that Oxford send you a paper copy of an Explanation of Benefits (EOB) after processing the claim. The EOB will let you know if there is any portion of the claim you need to pay. If any claims are denied in whole or in part, the EOB will include the reason for the denial or partial payment. If you would like paper copies of the EOBs, you may call the toll-free Customer Service number on your ID card to request them. You can also view and print all of your EOBs online **oxfordhealthplans.com.**

Limitation of action

You cannot bring any legal action against the Plan Administrator or the Claims Administrator for any other reason unless you first complete all the steps in the appeal process described in this section. After completing that process, if you want to bring a legal action against the Plan Administrator or the Claims Administrator you must do so within three years of the date you are notified of the final decision on your appeal or you lose any rights to bring such an action against the Plan Administrator or the Claims Administrator.

Claim denials and appeals

The Plan's Grievance Procedure provides for a meaningful, dignified and confidential procedure to hear and resolve Grievances between Participants, Oxford and, when necessary, Network Providers. This Grievance Procedure also assures that Grievances are handled in a timely manner.

To make this process more accessible to non-English speaking Participants, Oxford will arrange to have an interpreter available who speaks your language. Because the interpreter will be an employee of an independent translating service, Oxford's ability to provide this service depends on the availability of the interpreter. Oxford may need to arrange to call you at a time when an appropriate interpreter is available. Additionally, you always have the right to designate a representative to represent you during the Grievance Procedure. You must provide us with a written consent in order for the designee to act on your behalf. A copy of the Grievance Procedure is available in many languages. Depending on availability, a copy in your language can be forwarded to you upon your request.

IMPORTANT: All Complaints and First Level Appeals must be initiated **180 days** from the receipt of the Explanation of Benefits, Denial Notice, or of the date when the Participant became aware of the issue that initiated the Complaint or Appeal.

Grievance overview

Grievance and Complaints are classified into two categories. The category of the specific issue will determine which process. You will need to follow in resolving your issue. The two categories are:

Benefit/administrative issues – The types of items that fall under this category include, but are not limited to, problems with any of Oxford's administrative policies, issues concerning access to providers, denials based on benefit exclusions or limitations, claims payment disputes, and administrative inquires.

Utilization review issues – This category includes those items, which concern Medically Necessary determinations. The Utilization Review category also includes determinations involving treatment or services that are considered "Experimental or Investigational."

Grievance procedure for benefit/administrative issues

Timeframes for Initial Determinations for Benefit/Administrative Issues

- A request for Service (Pre-Service); Oxford will inform you and your Provider of Oxford's decision, by telephone and in writing, no later than 15 days from receipt of the request.
- Coverage for a service already rendered; (Post-Service); Oxford will inform you of Oxford's decision within 30 days of Oxford's receipt of the claim.
- A request for Urgent Care; Oxford will inform You or your provider, Subject to Medical Appropriateness, not later than 72 hours after the receipt of the claim. This includes any claim for medical service that if subjected to the standard time frames, could seriously jeopardize the life or health of the covered person, or the ability to regain maximum function, or in the opinion of a physician with knowledge of the Participant's condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

Please note: The Grievance Procedure described below should be used when you have a problem with any of Oxford's policies, procedures or determinations (Oxford's administrative procedures, access to providers, failure to use a Network Provider, Covered benefits under the SPD, etc.) except for issues concerning Medical Necessity. All issues concerning Oxford's determination of Medical Necessity must be resolved through the Grievance Procedure for Utilization Review Issues process.

There are two basic elements to the Grievance Procedure for Benefit/ Administrative Issues for Participants, Complaints and Appeals, as described below:

If your claim is denied

If a claim for Benefits is denied in part or in whole, you may call Oxford at the Customer Service number on your ID card before requesting a formal appeal. If Oxford cannot resolve the issue to your satisfaction over the phone, you have the right to file a formal appeal as described below.

How to appeal a denied claim

If you wish to appeal a denied pre-service request for Benefits, post-service claim or a rescission of coverage as described below, you or your authorized representative must submit your appeal in writing within 180 days of receiving the adverse benefit determination. You do not need to submit Urgent Care appeals in writing. This communication should include:

- The patient's name and ID number as shown on the ID card;
- The provider's name;
- The date of medical service;
- The reason you disagree with the denial; and
- Any documentation or other written information to support your request.

You or your authorized representative may send a written request for an appeal to:

Oxford Health Plans
Issue Resolution Department
P.O. Box 7081
Bridgeport, CT 06601-7081

Grievance Review Board
48 Monroe Turnpike
Trumbull, CT 06611

Medical Management Appeals
Oxford Health Plans
P.O. Box 7078
Bridgeport, CT 06601

For Urgent Care requests for Benefits that have been denied, you or your provider can call Oxford at the toll-free Customer Service number on your ID card to request an appeal.

Types of claims

The timing of the claims appeal process is based on the type of claim you are appealing. If you wish to appeal a claim, it helps to understand whether it is an:

- Urgent care request for Benefits;
- Pre-service request for Benefits;
- Post-service claim; or
- Concurrent claim.

Review of an appeal

When the Appeal Administrator receives your appeal, it will assign an Appeal Coordinator to manage your appeal throughout the appeal process. The Appeal Administrator will send you a letter identifying your Appeal Coordinator. That letter will include detailed information on the appeal process. Your Appeal Coordinator is available to answer any questions you may have about your appeal. Feel free to contact your Appeal Coordinator if you have any questions or concerns about the appeal process.

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

Oxford will conduct a full and fair review of your appeal. The appeal may be reviewed by:

> An appropriate individual(s) who did not make the initial benefit determination; and

> A health care professional with appropriate expertise who was not consulted during the initial benefit determination process.

Once the review is complete, if Oxford upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial and information on how to file a Second level Appeal.

Filing a second appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from Oxford within 60 days from receipt of the first level appeal determination. Oxford will acknowledge the receipt of your Appeal within 15 business days of the receipt of the Appeals requests. The acknowledgement will include the name, address and telephone number of the individual who has been designated to investigate your Appeal and indicate if any additional information is needed.

The Appeal Coordinator will make its decision on the Second Level Appeal within 15 days after receiving the completed appeal for a pre-service denial and 30 days after receiving the completed post-service appeal. The Appeal Coordinator will rule that either the Appeal is valid and recommend corrective action to resolve the matter or rule that the Appeal is without merit and does not require further action.

Note: Upon written request and free of charge, any Covered Persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. Oxford will review all claims in accordance with the rules established by the U.S. Department of Labor.

Grievance procedure for utilization review issues

Please note: This procedure must be used whenever your issue concerns Oxford's determination that a Covered Service is not Medically Necessary. Complaints and Appeals concerning all other Non-Medical Necessity determinations will be addressed through the **Grievance Procedure for Benefit/Administration Issues** as described above.

Utilization review

Covered Services are subject to Utilization Review. This means that our Medical Management Department reviews pertinent medical information in order to determine whether or not the proposed service (request for Precertification), the service currently being provided ("Concurrent Review"), or the service that was provided ("Retrospective Review") is a Covered Service under this SPD and Medically Necessary. If any of the following occur because Oxford has made the determination that such service is not Medically Necessary ("Adverse Determination"), you may appeal that determination:

> **A request for Precertification.** Oxford will inform you and your Provider of its decision, by telephone and in writing, no later than two business days from receipt of the necessary information.

- **Coverage for a current service for a Participant in an ongoing course of treatment.** Oxford will inform you and/or your Provider of it's decision, by phone and in writing, within 1 business day of our receipt of all necessary information; Coverage for a urgent current service for a Participant in an ongoing course of treatment shall be decided as soon as possible, taking into account the medical exigencies, Oxford will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the plan, provided that any such claim is made to the plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.
- **Coverage for a service already received is denied (Retrospective Review).** Oxford will inform you of its decision within 30 days of Oxford's receipt of the claim. The timeframes stated in this section might change if Oxford needs additional information from you in order to process your claim, or request for Precertification.
- **A request for Service (Pre-Service).** Oxford will notify you or your provider within two business days that there is a lack of information to process your request for service. You will have up to 45 days to provide the additional information. The 45-day period is calculated from the date you receive Oxford's request for information. A determination will be rendered within two business days of receipt of the additional information, if received within 45 days, or 15 days from the expiration of the period of time allowed to provide the information.

Note: Oxford will notify you or your provider within 30 days that there is a lack of information to process your claim for a service already rendered. You will have up to 45 days to provide the additional information. The 45-day period is calculated from the date you receive Oxford's request for information. A determination will be rendered within 15 days of receipt of the additional information, if received within 45 days, or 15 days from the expiration of the period of time allowed to provide the information.

- **A request for Urgent Care.** For Urgent Care Services, information will be requested by Oxford within 24 hours of receipt of the request; you will have 48 hours to provide Oxford with the information necessary to complete your request for service. Oxford will render a decision within 48 hours of receipt of the information, or the expiration of the original request for additional information, whichever is sooner.

In all cases, if no information is received within the required timeframes, the claim or request for service will be denied.

Appeal procedure for utilization review issues

Adverse Determinations relating to Precertification and Concurrent Review may be appealed by the Participant's Provider, Participant or the Participant's designee. You must provide us with a written consent in order for the designee to act on your behalf.

Retrospective Adverse Determinations may be appealed by either the Participant, the Participant's designee or the Participant's Provider.

All Appeals may be initiated either in writing or by telephone. Clinical personnel who did not participate in the initial review will review all Appeals.

First level appeal

After you are informed of the Adverse Determination, you, your designee or your Provider (if applicable) have up to 180 days to initiate the Appeal process. The person initiating the Appeal must write or telephone Oxford within this 180-day period. To initiate an Appeal, please call Customer Services at **1-800-444-6222** or write to

Clinical Appeals Department
P.O. Box 7078
Bridgeport, CT 06601-7078.

Oxford will acknowledge the receipt of Your Appeal within five business days of the receipt of the Appeal requests. The acknowledgment will include the name, address and telephone number of the individual who has been designated to investigate your Appeal.

Oxford will advise you, your designee, or Provider (if applicable) of its decision:

- Not later than 5 business days from the Clinical Appeals Department's receipt of an Appeal for services that have already been received or for the request for Precertification or Concurrent Care

Not later than 72 hours of receipt of a request for Urgent Precertification or Concurrent services.

If the Adverse Determination is upheld, you will receive written or electronic notification. Oxford's response will include its decision on the Appeal as well as the detailed reasons for the decision, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on how to file a Second Level Appeal, along with information on how to obtain information relevant to the claimant's claim for benefits. If you disagree with the First Level Appeal determination you may appeal to the Grievance Review Board described below under Second Level Appeal.

Second level appeal

If you are still dissatisfied with the results after the First Level Appeal has been completed, you or your designee may file your written Appeal with the Grievance Review Board ("the Board"). This Appeal must be filed within 60 business days of the date on which you received notice of the First Level Appeal determination letter. Oxford will respond to the receipt of the Participant's appeal within 10 business days of receipt of the Appeal request. The response will include the name, address, and telephone number of the individual who has been designated to investigate your Appeal.

"The Board" will make its decisions not later than:

- 30 business days from the Board's receipt of an Appeal for services that has already been received.
- 15 calendar days from the Board's receipt of an Appeal for the request for Precertification or Concurrent Care.
- 72 hours of receipt of a request for Urgent Precertification or Concurrent services.

Oxford may extend the review period for up to an additional 20 business days when there is a reasonable cause for delay beyond Oxford's control. Written notification to the Participant and Provider will be sent within the original 20 business days notifying the Participant of the extended timeframe.

The Board will:

- Rule that the Appeal is valid and recommend corrective action to resolve the matter; or
- Rule that the Appeal is without merit and does not require further action.

You will receive written notice of the Board's decision. The written notice will include detailed reasons for the determination and clinical rationale when applicable, along with references to any applicable specific plan provisions on which the benefit determination was based. It will also include information on the Participant's right to file an External Appeal, along with any forms required to initiate such an appeal.

The ruling of the Grievance Review Board will be the Plan's final position.

All information pertaining to each initial Adverse Determination and Appeal will be fully documented, and Oxford will retain such records for at least three years.

In the event Oxford fails to comply with any of the deadlines for completion of the internal utilization management determination appeals, or in the event that the Plan for any reason expressly waives its rights to an internal review of any appeal, then the Participant and /or provider shall be relieved of his or her obligation to complete the Plan internal review process and may at his or her option, proceed directly to the External Appeal Process.

Employee Retirement Income Security Act (ERISA) rights

After all levels of Appeals have been completed, the Participant may have the right to file a civil action under 502(a) of the Employee Retirement Income Security Act. ERISA rights do not apply if the Participant's coverage for health benefits was:

- Obtained through employment with a church or government group; or
- Purchased as an individual plan from Oxford.

Federal external review program

If, after exhausting your internal appeals, you are not satisfied with the determination made by Oxford, or if Oxford fails to respond to your appeal in accordance with applicable regulations regarding timing, you may be entitled to request an external review of Oxford's determination.

If one of the above conditions is met, you may request an external review of adverse benefit determinations based upon any of the following:

- Clinical reasons;
- The exclusions for experimental or investigational services or unproven services;
- Rescission of coverage (coverage that was cancelled or discontinued retroactively); or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review, in urgent situations as detailed below, by calling the toll-free number on your ID card or by sending a written request to the address set out in the determination letter. A request must be made within four months after the date you received Oxford's decision.

An external review request should include all of the following:

- A specific request for an external review;
- The Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review will be performed by an Independent Review Organization (IRO). Oxford has entered into agreements with three or more IROs that have agreed to perform such reviews. There are two types of external reviews available:

- A standard external review; and
- An expedited external review.

Standard external review

A standard external review is comprised of all of the following:

- A preliminary review by Oxford of the request;
- A referral of the request by Oxford to the IRO; and
- A decision by the IRO.

Within the applicable timeframe after receipt of the request, Oxford will complete a preliminary review to determine whether the individual for whom the request was submitted meets all of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided;
- Has exhausted the applicable internal appeals process; and
- Has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the preliminary review, Oxford will issue a notification in writing to you. If the request is eligible for external review, Oxford will assign an IRO to conduct such review. Oxford will assign requests either by rotating claims assignments among the IROs or by using a random selection process.

The IRO will notify you in writing of the request's eligibility and acceptance for external review. You may submit in writing to the IRO within ten business days following the date of receipt of the notice additional information that the IRO will consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted by you after ten business days.

Oxford will provide to the assigned IRO the documents and information considered in making Oxford's determination. The documents include:

- All relevant medical records;
- All other documents relied upon by oxford; and
- All other information or evidence that you or your physician submitted. If there is any information or evidence you or your physician wish to submit that was not previously provided, you may include this information with your external review request and oxford will include it with the documents forwarded to the IRO.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide written notice of its determination (the "Final External Review Decision") within 45 days after it receives the request for the external review (unless they request additional time and you agree). The IRO will deliver the notice of Final External Review Decision to you and Oxford, and it will include the clinical basis for the determination.

Upon receipt of a Final External Review Decision reversing Oxford determination, the Plan will immediately provide coverage or payment for the benefit claim at issue in accordance with the terms and conditions of the Plan, and any applicable law regarding plan remedies. If the Final External Review Decision is that payment or referral will not be made, the Plan will not be obligated to provide Benefits for the health care service or procedure.

Expedited external review

An expedited external review is similar to a standard external review. The most significant difference between the two is that the time periods for completing certain portions of the review process are much shorter, and in some instances you may file an expedited external review before completing the internal appeals process.

You may make a written or verbal request for an expedited external review if you receive either of the following:

- An adverse benefit determination of a claim or appeal if the adverse benefit determination involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function and you have filed a request for an expedited internal appeal; or
- A final appeal decision, if the determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the individual or would jeopardize the individual's ability to regain maximum function, or if the final appeal decision concerns an admission, availability of care, continued stay, or health care service, procedure or product for which the individual received emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request, Oxford will determine whether the individual meets both of the following:

- Is or was covered under the Plan at the time the health care service or procedure that is at issue in the request was provided.
- Has provided all the information and forms required so that Oxford may process the request.

After Oxford completes the review, Oxford will immediately send a notice in writing to you. Upon a determination that a request is eligible for expedited external review, Oxford will assign an IRO in the same manner Oxford utilizes to assign standard external reviews to IROs. Oxford will provide all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the same type of information and documents considered in a standard external review.

In reaching a decision, the IRO will review the claim anew and not be bound by any decisions or conclusions reached by Oxford. The IRO will provide notice of the final external review decision for an expedited external review as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request. If the initial notice is not in writing, within 48 hours after the date of providing the initial notice, the assigned IRO will provide written confirmation of the decision to you and to Oxford.

You may contact Oxford at the toll-free number on your ID card for more information regarding external review rights, or if making a verbal request for an expedited external review.