

Medical

The Citigroup Health Benefit 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™ (YBR™), available through My Total Compensation and Benefits, lists the medical options available to you based on your home zip code (or your work zip code if you live in Canada).

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

- > ChoicePlan 500 (CP500), administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan); or
- > High Deductible Health Plan (HDHP), administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan).

HMOs:

1. Health Plan Hawaii Plus (HMSA);
2. SelectHealth (Utah and part of Idaho);
3. Kaiser FHP of California — Northern; and
4. Kaiser FHP of California — Southern.



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Administrators of the ChoicePlan 500 (CP500) and High Deductible Health Plan (HDHP)

The CP500 and HDHP are administered by Aetna and Anthem BlueCross BlueShield throughout the United States. The plan designs for the CP500 and the HDHP are essentially the same no matter which vendor administers the plan. The CP500 and HDHP are self-insured, meaning these plans are not subject to state laws and Citi pays the claims incurred.

Medical Options at a Glance

Although each of the Citi medical plans offers comprehensive coverage, there are differences between the plans. Some high-level information is available in the table below. For HMO information, visit “2021 Insured HMOs” on page 109 or see the Health Plan Comparison Charts on Your Benefits Resources™ (YBR™). To access YBR™, visit My Total Compensation and Benefits at www.totalcomponline.com, available from the Citi intranet and the Internet.

Note: Precertification is required for certain procedures and services both in network and out of network. Penalties may apply if precertification is not obtained. Call your plan at the number listed on the back of your ID card for details.

For in-network covered expenses, the plans pay a percentage of discounted rates, while for out-of-network charges, the plans pay a percentage of the maximum allowed amount (MAA). See the *Glossary* section for a definition of MAA, which is sometimes referred to as “Recognized Charges.” For out-of-network services, providers may balance-bill you for the charges above MAA, and you are responsible for those charges.

Need Help Finding a Doctor or a Specialist for a Second Opinion?

Contact Health Advocate at
1 (866) 449-9933 or visit your
plan provider’s website (Aetna
or Anthem BlueCross
BlueShield) for more
information.

Remember: You can save on out-of-pocket costs by using providers who participate in the plan's network. If you use an out-of-network doctor, you'll pay more when you need care.

ChoicePlan 500		
Administered by Aetna and Anthem BlueCross BlueShield		
	In-network	Out-of-network
Annual deductible		
<i>Individual</i>	\$500 ¹	\$1,500 ¹
<i>Maximum per family</i>	\$1,000 ¹	\$3,000 ¹
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance and medical copays)		
Note: There is a separate out-of-pocket maximum for prescription drug expenses		
<i>Individual</i>	\$3,000 ¹	\$6,000 ¹
<i>Maximum per family</i>	\$6,000 ¹	\$12,000 ¹
<i>Lifetime maximum</i>	None	None
Professional care (in office)		
<i>Doctor/primary care physician (PCP) visits</i>	80% after deductible ² ,	60% of MAA after deductible ²
<i>Specialist visits</i>	80% after deductible;	60% of MAA after deductible ²
Preventive care (subject to frequency limits)		
<i>Well-adult visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible up to \$250 combined maximum, ³ then covered at 60% of MAA, not subject to deductible
<i>Well-child visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible up to \$250 combined maximum, ³ then covered at 60% of MAA, not subject to deductible
<i>Adult and child routine immunizations</i>	100%, not subject to deductible	60% of MAA, not subject to deductible
<i>Routine cancer screenings</i> (Pap , mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible up to \$250 combined maximum, ³ then covered at 60% of MAA, not subject to deductible
<i>Contraceptive devices</i>	100%, not subject to deductible, for diaphragms and Mirena, an implantable device, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see "Preventive Care" beginning on page 67). All other implantable devices will be covered at 80% after deductible. ²	60% of MAA after deductible ²
<i>Voluntary sterilization</i> (tubal ligation, sterilization implants and surgical sterilizations)	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) and abortions are covered at 80% after deductible. ²	60% of MAA after deductible ²

ChoicePlan 500		
Administered by Aetna and Anthem BlueCross BlueShield		
	In-network	Out-of-network
Hospital emergency room (no coverage in any medical option if not a true emergency)		
	80% after deductible; ² precertification is required for hospitalization and certain outpatient procedures.	80% of MAA after deductible; ² precertification is required for hospitalization and certain outpatient procedures
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
<i>Ambulance</i>	80% after deductible ² for transport to and from the nearest medical facility qualified to give the required treatment; precertification required for air transport	80% of MAA after deductible ² for transport to and from the nearest medical facility qualified to give the required treatment; precertification required for air transport
Urgent care center/Walk-in clinics		
	80% after deductible ²	80% of MAA after deductible ²
Hospital (inpatient and outpatient services)		
<i>Semiprivate room and board, doctor's charges, lab, radiology and X-ray</i>	80% after deductible; ² precertification required for hospitalization and certain outpatient procedures	60% of MAA after deductible; ² precertification required for certain outpatient procedures
<i>Anesthesia</i>	80% after deductible ²	60% of MAA after deductible ²
Non-routine outpatient		
<i>Lab, radiology and X-ray</i>	80% after deductible; ² precertification required for certain outpatient procedures	60% of MAA after deductible; ² precertification required for certain outpatient procedures
Mental health and substance abuse		
<i>Inpatient</i>	80% after deductible; ² precertification required	60% of MAA after deductible; ² precertification required
<i>Outpatient</i>	80% after deductible; ² precertification required for certain outpatient procedures	60% of MAA after deductible; ² precertification required for certain outpatient procedures
Therapies		
<i>Physical/occupational therapy (combined)</i> Limited to 60 visits per plan year for in-network and out-of-network combined You may be eligible for additional visits at a lower benefit level with plan approval after a medical necessity review	80% after deductible; ² 70% after deductible ² for approved visits over plan limits	60% of MAA after deductible; ² 50% of MAA after deductible ² for approved visits over plan limits
<i>Speech therapy</i> Limited to 90 visits per plan year for in-network and out-of-network combined You may be eligible for additional visits at a lower benefit level with plan approval after a medical necessity review	80% after deductible; ² 70% after deductible ² for additional visits over plan limits	60% of MAA after deductible; ² 50% of MAA after deductible ² for additional visits over plan limits
<i>Chiropractic therapy</i> Limited to 20 visits per plan year for in-network and out-of-network combined	80% after deductible ²	60% of MAA after deductible ²

	ChoicePlan 500 Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	Out-of-network
<i>Acupuncture</i> Must be administered by a medical doctor or a licensed acupuncturist	80% after deductible ²	60% of MAA after deductible ²
<i>Applied behavior analysis therapy</i>	80% after deductible	60% of MAA after deductible

- ¹ The annual deductible and out-of-pocket maximum combine in-network and out-of-network expenses.
- ² 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 by cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (HCSA).
- ³ Combined maximum benefit applies to well-adult visits, well-child visits, routine cancer screenings, routine hearing exams and routine vision care. The maximum is measured on a calendar year basis.

	High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	Out-of-network
Annual deductible (in-network and out-of-network combined)		
<i>Individual</i>	\$1,800 ¹ Includes prescription drug expenses	\$2,800 ¹ Includes prescription drug expenses
<i>Maximum per family (no benefits will be paid to an individual until the family deductible has been met)</i>	\$3,600 ¹ Includes prescription drug expenses	\$5,600 ¹ Includes prescription drug expenses
Annual out-of-pocket maximum (includes deductible, medical and prescription drug coinsurance and medical and prescription drug copays; in-network and out-of-network combined)		
<i>Individual</i>	\$5,000 Includes prescription drug expenses	\$7,500 Includes prescription drug expenses
<i>Maximum per family²</i>	\$10,000 (\$6,850 per individual) Includes prescription drug expenses	\$15,000 (\$15,000 per individual) Includes prescription drug expenses
<i>Lifetime maximum</i>	None	None
Professional care (in office)		
<i>Doctor/primary care physician (PCP) visits</i>	80% after deductible ³	60% of MAA after deductible ³
<i>Specialist visits</i>	80% after deductible ³	60% of MAA after deductible ³
Preventive care (subject to frequency limits)		
<i>Well-adult visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible
<i>Well-child visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible
<i>Adult and child immunizations</i>	100%, not subject to deductible	100% of MAA, not subject to deductible

High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield		
	In-network	Out-of-network
<i>Routine cancer screenings</i> (Pap smear mammogram, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible
<i>Contraceptive devices</i>	100%, not subject to deductible, for diaphragms and Mirena, an implantable device, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see "Preventive Care" beginning on page 67). All other implantable devices will be covered at 80% after deductible. ³	60% of MAA after deductible ³
<i>Voluntary sterilization</i> (including tubal ligation, sterilization implants and surgical sterilizations)	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) and abortions are covered at 80% after deductible. ³	60% of MAA after deductible ³
Hospital emergency room (no coverage in any medical option if not a true emergency)		
	80% after deductible; ³ precertification required if admitted	80% after deductible; ³ precertification required if admitted
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
<i>Ambulance</i>	80% after deductible; ³ precertification required for air transport	80% of MAA after deductible; precertification required for inter-facility transfers
Urgent care center/Walk-In clinics		
	80% after deductible ³	80% of MAA after deductible
Hospital (inpatient and outpatient services)		
<i>Semiprivate room and board, doctor's charges, lab, radiology and X-ray</i>	80% after deductible; ³ precertification required for hospitalization and certain outpatient procedures	60% of MAA after deductible; ³ precertification required for hospitalization and certain outpatient procedures
<i>Anesthesia</i>	80% after deductible ³	60% of MAA after deductible ³
Non-routine outpatient		
<i>Lab, radiology and X-ray</i>	80% after deductible; ³ precertification required for certain outpatient procedures	60% of MAA after deductible; ³ precertification required for certain outpatient procedures
Mental health and substance abuse		
<i>Inpatient</i>	80% after deductible; ³ precertification required	60% of MAA after deductible; ³ precertification required
<i>Outpatient</i>	80% after deductible ³	60% of MAA after deductible ³

	High Deductible Health Plan (HDHP) Administered by Aetna and Anthem BlueCross BlueShield	
	In-network	Out-of-network
Therapies		
<i>Physical/occupational therapy (combined)</i> Limited to 60 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	80% after deductible; ³ 70% after deductible ³ for approved visits over plan limits	60% of MAA after deductible; ³ 50% of MAA after deductible ³ for approved visits over plan limits
<i>Speech therapy</i> Limited to 90 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	80% after deductible; ³ ; 70% after deductible ³ for additional visits over plan limits	60% of MAA after deductible; ³ ; 50% of MAA after deductible ³ for additional visits over plan limits
<i>Chiropractic therapy</i> Limited to 20 visits a year in-network and out-of-network combined	80% after deductible ³	60% of MAA after deductible ³
<i>Acupuncture</i> Must be administered by a medical doctor or a licensed acupuncturist	80% after deductible ³	60% of MAA after deductible ³
<i>Applied behavior analysis therapy</i>	80% after deductible ³	60% of MAA after deductible ³

- 1 The annual deductible combines in-network and out-of-network expenses.
- 2 In the HDHP, the out-of-network family out-of-pocket maximum can be satisfied as a family or by an individual within the family. For in-network services, each of your covered family members has an individual out-of-pocket maximum of only \$6,850. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the \$10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the family's in-network health care expenses for the rest of the year.
- 3 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 by cash or check or with before-tax dollars if you have available funds in a Health Savings Account (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 visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care;
- > Certain U.S. 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 Plan/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); and
- > Screening for gestational diabetes.

Additional preventive care services covered in full by Citi medical plans as part of the Affordable Care Act (also referred to as PPACA) include:

- > Preventive services related to pregnancy for dependent children;
- > Anesthesia performed in connection with a preventive colonoscopy;
- > Genetic counseling and BRCA genetic testing for women who have had non-BRCA-related breast or ovarian cancer;
- > Gender-based preventive services for transgender individuals;
- > Human immune-deficiency virus (HIV) counseling and screening for all sexually active people;
- > Interpersonal and domestic violence screening and counseling;
- > Counseling on sexually transmitted infections for all sexually active people;
- > Tobacco-use cessation (for non-pregnant adults): counseling, behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy;

Access Doctors on Demand.

If you're a member of a Citi Aetna or Anthem BlueCross Blue Shield medical plan, you have access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical or mental health issues via phone or online video consultation. Learn more about Aetna's Teladoc service at www.teladoc.com or about Anthem's LiveHealth Online service at www.livehealthonline.com.

- > Tobacco-use cessation (for pregnant women): counseling and behavioral interventions;
- > Diabetes screening (at-risk adults): screening for abnormal blood glucose as part of cardiovascular risk assessment for overweight or obese adults ages 40-70 years; and intensive behavioral counseling about diet and exercise for patients with abnormal blood glucose; and
- > High blood pressure screening (adults): hypertension screening for adults ages 18 and older.

Contact your 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. (See the current guidelines at www.uspreventiveservicestaskforce.org.)

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 ages 45-75, 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 120-139 systolic/80-90 diastolic;
- > **Lipid disorders** — covered for men ages 20-35 and women ages 20-45 if at high risk, and for men over 35 and 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 ages 65-75 who have ever smoked;
- > **Breast cancer** — covered every one to two years starting at age 40;
- > **Genetic testing for breast and ovarian cancer (BRCA)** — covered for women with family history BRCA1 or BRCA2;
- > **Cervical cancer** — covered for sexually active women ages 21-65;
- > **Osteoporosis** — covered for post-menopausal women ages 60-85;
- > **Chlamydia** — covered for sexually active people who are under age 24 or pregnant;
- > **Gonorrhea** — covered for sexually active people who are under age 24 or a 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 ages 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; and
- > **Obesity** — covered for adults and children age 6 and older, including intensive counseling and behavioral interventions.

Specific preventive care guidelines may apply depending on your Plan Administrator. For details, log on to the carrier's website (Aetna: www.aetna.com. Anthem BlueCross BlueShield: www.anthem.com) or call the number on the back of your ID card.

Important Note:

For details on the frequency and age limits that apply to routine cancer screenings, contact your physician, log on to the carrier's website (Aetna: www.aetna.com or Anthem BlueCross BlueShield: www.anthem.com) or call the number on the back of your ID card.

Screening and Counseling Services

Covered expenses include charges made by your physician, psychologist or therapist 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 or Anthem BCBS. 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 that are covered to any extent under any other part of this plan;
- > Services that are for diagnosis or treatment of a suspected or identified illness or injury;
- > Exams given during your inpatient stay for medical care;
- > Services not given by a physician or under his or her direction; and
- > 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 U.S. Food and 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 that 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 per calendar year.

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 per calendar year.

Routine hearing and vision tests are covered in network at 100%, not subject to deductible

Routine Cancer Screenings

In the ChoicePlan 500 (CP500) and High Deductible Health Plan (HDHP), cancer-screening tests are covered 100% with no deductible 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.

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 that 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 on to the medical carrier's website (Aetna: www.aetna.com. Anthem BlueCross BlueShield: www.anthem.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 representative 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).

Know Where to Go for Care?

Do you know when to go the emergency room, urgent care center or your doctor? Test your knowledge with the Right Place to Get Care quiz.

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 that if group health plans and health insurance issuers decide to provide mental health or substance use disorder (MH/SUD) benefits, they must ensure that financial requirements (such as copays and deductibles) and treatment limitations (such as visit limits) applicable to MH/SUD benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

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. If you do not precertify, your claim may be denied in whole or in part. 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 (CP500) or the High Deductible Health Plan (HDHP), 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.

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 (used with medical procedures as part of testing for prediction of memory dysfunction that may be a result of brain surgery);
- > Biofeedback;
- > Psychological testing;
- > ABA — applied behavior analysis;
- > Electroconvulsive therapy;
- > Neuropsychological testing;
- > Bariatric services;
- > Cardiovascular services;
- > Musculoskeletal services; and
- > Gender affirmation surgery.

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

Mental Health/Substance Abuse

You must call Aetna for precertification before you obtain covered inpatient mental health and/or substance abuse treatment, including stays in a residential treatment facility or a partial hospitalization program, outpatient detoxification, 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 123 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 152.

Precertification Requirements for Anthem BlueCross BlueShield Plans

You are required to obtain precertification for both in-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 Anthem BlueCross BlueShield determines that the services and supplies are covered under the plan.

You are required to obtain precertification for the following services:

- > Inpatient admission:
 - Inclusive of all acute inpatient, skilled nursing facility, long-term acute rehab, and OB delivery stays beyond the federal mandate minimum length of stay (including newborn stays beyond the mother's stay);
 - Emergency admissions (requires plan notification no later than two business days after admission);
- > Outpatient and surgical services:
 - Air ambulance (excludes 911 initiated emergency transport);
 - Bone-anchored and bone conduction hearing aids;
 - Cochlear implants and auditory brainstem implants;
 - Corneal collagen cross-linking;
 - Cryopreservation of oocytes or ovarian tissue;

- Diaphragmatic/phrenic nerve stimulation pacing systems;
- Deep brain, cortical, and cerebellar stimulation;
- Electric tumor treatment field (TTF) for treatment of glioblastoma;
- Immunoprophylaxis for respiratory syncytial virus (RSV);
- Implantable middle ear hearing aids;
- Intraocular anterior segment aqueous drainage devices (without extraocular reservoir);
- Keratoprosthesis;
- MRI guided high intensity focused ultrasound ablation for non-oncologic indications;
- Occipital nerve stimulation;
- Percutaneous neurolysis for chronic neck and back pain;
- Photocoagulation of macular drusen;
- Private duty nursing;
- Presbyopia and stigmatism – correcting intraocular lenses;
- Radiofrequency ablation to treat tumors outside the liver;
- Transendoscopic therapy for gastroesophageal reflux disease and dysphagia;
- Treatment of hyperhidrosis;
- Treatments for urinary incontinence;
- Transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation (Radiofrequency and Cryoablation);
- Transcatheter uterine artery embolization;
- Treatment of temporomandibular disorders;
- Vagus nerve stimulation;
- > Diagnostic testing:
 - Cardiac Ion channel genetic testing;
 - Chromosomal microarray analysis (CMA) for developmental delay, Autism Spectrum Disorder, intellectual disability (intellectual developmental disorder) and congenital anomalies;
 - Gene expression profiling for managing breast cancer treatment;
 - Genetic testing for breast and/or ovarian cancer syndrome;
 - Genetic testing for cancer susceptibility;
 - Preimplantation genetic diagnosis testing;
 - Wireless capsule for the evaluation of suspected gastric and intestinal motility disorders;
 - Prostate saturation biopsy;
- > Durable medical equipment (DME)/prosthetics:
 - Augmentative and alternative communication (AAC) devices/ speech generating devices (SGD);
 - Continuous interstitial glucose monitoring;
 - Dynamic low-load prolonged-duration stretch devices (LLPS);

- Electrical Bone Growth Stimulation;
- External (portable) continuous insulin infusion pump;
- Functional electrical stimulation (FES); threshold electrical stimulation (TES);
- Implantable infusion pumps;
- Lower limb prosthesis and microprocessor controlled lower limb prosthesis;
- Oscillatory devices for airway clearance including high frequency chest compression and intrapulmonary percussive ventilation (IPV);
- Ultrasound bone growth stimulation;
- Wheeled mobility devices: wheelchairs-powered, motorized, with or without power seating systems and power operated vehicles (POVs);
- Prosthetics: electronic or externally powered and select other prosthetics- (myoelectric-UE);
- Standing frame;
- Transtympanic micropressure for the treatment of Ménière's Disease;
- > Radiation therapy/radiology services:
 - Intensity modulated radiation therapy (IMRT);
 - Single photon emission computed tomography (SPECT) scans for noncardiovascular indications;
 - Proton beam therapy;
 - Stereotactic radiosurgery (SRS) and stereotactic body radiotherapy (SBRT);
 - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for treating primary or metastatic liver tumors;
 - Transcatheter arterial chemoembolization (TACE) and transcatheter arterial embolization (TAE) for malignant lesions outside the liver- except CNS and spinal cord;
 - Wireless capsule endoscopy for gastrointestinal imaging and the patency capsule;
- > Surgical services:
 - Ablative techniques as a treatment for Barrett's esophagus;
 - Autologous cellular immunotherapy for the treatment of prostate cancer;
 - Balloon and self-expanding absorptive sinus ostial dilation;
 - Bariatric surgery and other treatments for clinically severe obesity;
 - Bronchial thermoplasty for treatment of asthma;
 - Cardio-vascular:
 - Cardiac resynchronization therapy (CRT) with or without an implantable cardioverter defibrillator (CRT/ICD) for the treatment of heart failure;
 - Carotid, vertebral and intracranial artery angioplasty with or without stent placement;
 - Endovascular techniques (percutaneous or open exposure) for arterial revascularization of the lower extremities);
 - Implantable ambulatory event monitors and mobile cardiac telemetry;
 - Implantable or wearable cardioverter-defibrillator;

- Mechanical circulatory assist devices (ventricular assist devices, percutaneous ventricular assist devices and artificial hearts);
- Mechanical embolectomy for treatment of acute stroke;
- Outpatient cardiac hemodynamic monitoring using a wireless sensor for heart failure management:
- Partial left ventriculectomy;
- Perirectal spacers for use during prostate radiotherapy;
- Transcatheter closure of patent foramen ovale and left atrial appendage for stroke prevention;
- Transcatheter heart valve procedures;
- Transmyocardial/periventricular device closure of ventricular septal defects;
- Treatment of varicose veins (lower extremities);
- Venous angioplasty with or without stent placement/ venous stenting;
- Cryosurgical ablation of solid tumors outside the liver;
- Functional endoscopic sinus surgery;
- Lung volume reduction surgery;
- Lower esophageal sphincter augmentation devices for the treatment of gastroesophageal reflux disease (GERD);
- Locally ablative techniques for treating primary and metastatic liver malignancies;
- Musculo-skeletal surgeries:
 - Axial lumbar interbody fusion;
 - Computer-assisted musculoskeletal surgical navigational orthopedic procedures of the appendicular system;
 - Extracorporeal shock wave therapy for orthopedic conditions;
 - Implanted devices for spinal stenosis;
 - Implanted (epidural and subcutaneous) spinal cord stimulators (SCS);
 - Lysis of epidural adhesions;
 - Manipulation under anesthesia of the spine and joints other than the knee;
 - Meniscal allograft transplantation of the knee;
 - Percutaneous vertebroplasty, kyphoplasty and sacroplasty;
 - Sacroiliac joint fusion;
 - Surgical interventions for scoliosis and spinal deformity;
 - Total ankle replacement;
 - Treatment of osteochondral defects of the knee and ankle;
- Ovarian and internal iliac vein embolization as a treatment of pelvic congestion syndrome;

- Plastic/reconstructive surgeries/treatments:
 - Abdominoplasty ,panniculectomy, diastasis recti repair;
 - Allogeneic, xenographic, synthetic and composite products for wound healing and soft tissue grafting hyperbaric oxygen therapy (systemic/topical);
 - Blepharoplasty;
 - Brachioplasty;
 - Breast procedures; including reconstructive surgery, Implants and other breast procedures;
 - Buttock/thigh lift;
 - Chin implant, mentoplasty, osteoplasty mandible;
 - Composite products for wound healing and soft tissue grafting;
 - Insertion/injection of prosthetic material collagen implants;
 - Hyperbaric oxygen therapy (systemic/topical);
 - Liposuction/lipectomy;
 - Mandibular/maxillary (orthognathic) surgery;
 - Mastectomy for gynecomastia;
 - Oral, pharyngeal and maxillofacial surgical treatment for obstructive sleep apnea or snoring;
 - Penile prosthesis implantation;
 - Procedures performed on the face, jaw or neck (including facial dermabrasion, scar revision);
 - Procedures performed on male or female genitalia;
 - Procedures performed on the trunk and groin;
 - Reduction mammoplasty;
 - Repair of pectus excavatum / carinatum;
 - Rhinoplasty;
 - Septoplasty;
 - Skin-related procedures;
 - Sacral nerve stimulation (SNS) and percutaneous tibial nerve stimulation (PTNS) for urinary and fecal incontinence and urinary retention;
 - Sacral nerve stimulation as a treatment of neurogenic bladder secondary to spinal cord injury;
 - Surgical and ablative treatments for chronic headaches;
 - Surgical and minimally invasive treatments for benign prostatic hyperplasia (BPH) and other GU conditions;
 - Surgical treatment of obstructive sleep apnea and snoring
 - Transanal hemorrhoidal dearterialization (THD);
 - Viscocanalostomy and canaloplasty;
- > Gender affirmation surgery;

- > Human organ and bone marrow/stem cell transplants;
 - Inpatient admits for ALL solid organ and bone marrow/stem cell transplants (Including kidney only transplants);
 - Outpatient: All procedures considered to be transplant or transplant related including but not limited to:
 - Stem cell/bone marrow transplant (with or without myeloablative therapy);
 - Donor leukocyte infusion;
 - Axicabtagene ciloleucel (CAR) T-cell immunotherapy treatment;
 - Gene therapy treatment & replacement
 - Intrathecal treatment of spinal muscular atrophy (SMA);
- > Out-of-network referrals:
 - Out-of-network services for consideration of payment at network benefit level (may be authorized, based on network availability and/or medical necessity.);
- > Mental health/substance abuse (MHSA):
 - Acute inpatient admissions;
 - Transcranial magnetic stimulation (TMS);
 - Intensive outpatient therapy (IOP);
 - Partial hospitalization (PHP);
 - Residential care;
 - Behavioral health in-home programs
- > Applied behavior analysis (ABA); and
- > Infertility treatment

If you or your physician does not agree with Anthem BlueCross BlueShield's determination, you may appeal the decision. For more information about the claims appeal process, see "Claims and Appeals for Anthem BlueCross BlueShield Medical Plan" on page 160 or call **1 (855) 593-8123**.

ChoicePlan 500 (CP500)

With the ChoicePlan 500, administered by Aetna (Choice POS II Open Access) and Anthem BlueCross BlueShield (PPO Preferred Provider Organization plan), you'll pay higher premiums, but have a lower deductible than the High Deductible Health Plan.

You must meet the annual deductible before the plan will share in the cost of benefits. Both in-network and out-of-network services will apply to meeting the deductible.

Here's an overview of the ChoicePlan 500's key features, which are the same whether you're enrolled through Aetna or Anthem.

CP500 at a Glance

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* section for a definition of MAA, which is sometimes referred to as “Recognized Charges.”

Type of Service	In Network	Out of Network
Annual deductible (in-network and out-of-network combined)		
<i>Individual</i>	\$500	\$1,500
<i>Maximum per family</i>	\$1,000	\$3,000
Annual medical out-of-pocket maximum (includes medical deductible, medical coinsurance and medical copays; in-network and out-of-network combined) Note: There is a separate annual out-of-pocket maximum for prescription drugs.		
<i>Individual</i>	\$3,000	\$6,000
<i>Maximum per family</i>	\$6,000	\$12,000
<i>Lifetime maximum</i>	None	None
Professional care (in office)		
<i>PCP visits</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Specialist visits</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Allergy treatment</i>	80% after deductible ² for the first office visit; 100% for each additional injection if office visit fee is not charged	60% of MAA after deductible ²
Preventive care (subject to frequency limits)		
<i>Well-adult visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible, up to \$250 combined maximum; ¹ then covered at 60% of MAA, not subject to deductible
<i>Well-child visits</i>	100%, not subject to deductible	100% of MAA, not subject to deductible, up to \$250 combined maximum; ¹ then covered at 60% of MAA, not subject to deductible
<i>Routine cancer screenings</i> (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening)	100%, not subject to deductible	100% of MAA, not subject to deductible, up to \$250 combined maximum; ¹ then covered at 60% of MAA, not subject to deductible
<i>Adult and child routine immunizations</i>	100%, not subject to deductible	60% of MAA, not subject to deductible

Type of Service	In Network	Out of Network
<i>Contraceptive devices</i>	100%, not subject to deductible, for diaphragms and Mirena, an implantable device, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see "Preventive Care" beginning on page 67). All other implantable devices will be covered at 80% after deductible. ²	60% of MAA after deductible ²
<i>Voluntary sterilization</i> (including tubal ligation, sterilization implants and surgical sterilizations)	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) and abortions are covered at 80% after deductible. ²	60% of MAA after deductible ²
Routine care (subject to frequency limits)		
<i>Routine vision exams</i>	100%, not subject to deductible, limited to one exam per calendar year	100% of MAA, not subject to deductible, up to \$250 combined maximum; ¹ then covered at 60% of MAA, not subject to deductible. Limited to one exam per calendar year.
<i>Routine hearing exams</i>	100%, not subject to deductible, limited to one exam per calendar year	100% of MAA, not subject to deductible, up to \$250 combined maximum; ¹ then covered at 60% of MAA, not subject to deductible. Limited to one exam per calendar year.
Hospital (inpatient and outpatient services)		
<i>Semiprivate room and board, doctor's charges, lab, X-ray, radiology and surgical care</i>	80% after deductible; ² precertification is required for hospitalization and certain outpatient procedures	60% of MAA after deductible; ² precertification is required for hospitalization and certain outpatient procedures
<i>Anesthesia</i>	80% after deductible ²	60% of MAA after deductible ²
Non-routine outpatient		
<i>Lab, X-ray and radiology</i>	80% after deductible; ² precertification is required for certain outpatient procedures	60% of MAA after deductible; ² precertification is required for certain outpatient procedures
Maternity care		
<i>Physician office visit</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Hospital delivery</i>	<ul style="list-style-type: none"> > 80% after deductible² > Precertification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery 	<ul style="list-style-type: none"> > 60% of MAA after deductible² > Prenotification required if admission exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section delivery

Type of Service	In Network	Out of Network
Emergency care (no coverage if not a true emergency)		
<i>Hospital emergency room</i> (includes emergency room facility and professional services provided in the emergency room)	<ul style="list-style-type: none"> > 80% after deductible² > Precertification is required for hospitalization and certain outpatient procedures 	<ul style="list-style-type: none"> > 80% of MAA after deductible² > Precertification is required for hospitalization and certain outpatient procedures
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
<i>Ambulance</i>	<ul style="list-style-type: none"> > 80% after deductible² for transport to and from the nearest medical facility qualified to give the required treatment > Precertification required for air transport 	<ul style="list-style-type: none"> > 80% of MAA after deductible² for transport to and from the nearest medical facility qualified to give the required treatment > Precertification required for air transport
Urgent care center/Walk-in clinic		
<i>Urgent care facility</i>	80% after deductible ²	80% of MAA after deductible ²
Outpatient short-term rehabilitation		
<i>Physical or occupational therapy</i> (All therapy visits are reviewed for medical necessity. PT/OT therapy visits are combined with a 60-visit per-year maximum. Additional visits may be approved.) This limit applies to in-network and out-of-network services combined.	<ul style="list-style-type: none"> > 80% after deductible² > 70% after deductible² for visits approved for medical necessity over plan limits 	<ul style="list-style-type: none"> > 60% of MAA after deductible² > 50% of MAA after deductible² for visits approved for medical necessity over plan limits
<i>Speech therapy</i> (90-visit per-year maximum. Additional visits may be approved.) This limit applies to in-network and out-of-network services combined.	<ul style="list-style-type: none"> > 80% after deductible² > 70% after deductible² for visits approved for medical necessity over plan limits 	<ul style="list-style-type: none"> > 60% of MAA after deductible² > 50% after deductible² for visits approved for medical necessity over plan limits
<i>Chiropractic therapy</i> (medically necessary), up to 20 visits per year for in-network and out-of-network services combined	80% after deductible ²	60% of MAA after deductible ²
Other services		
<i>Durable medical equipment</i> (includes orthotics/ prosthetics and appliances)	80% after deductible ²	60% of MAA after deductible ²
<i>Private-duty nursing and home health care</i> (ventilator management services are considered a skilled need)	80% after deductible, ² limited to 200 visits annually for in-network and out-of-network services combined; precertification required	60% of MAA after deductible, ² limited to 200 visits annually for in-network and out-of-network services combined; precertification required
<i>Hospice</i>	80% after deductible; ² precertification required	60% of MAA after deductible; ² precertification required
<i>Skilled nursing facility</i>	80% after deductible ² (limited to 120 days annually for in-network and out-of-network services combined); precertification required	60% of MAA after deductible ² (limited to 120 days annually for in-network and out-of-network services combined); precertification required

Type of Service	In Network	Out of Network
<i>Infertility treatment</i>	<ul style="list-style-type: none"> > Covered up to a \$24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 80% after deductible² up to the lifetime maximum; precertification required > Prescriptions covered through CVS Caremark up to a \$7,500 lifetime pharmacy maximum per person 	<ul style="list-style-type: none"> > Covered up to a \$24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 60% after deductible² up to the lifetime maximum; precertification required > Prescriptions covered through CVS Caremark up to a \$7,500 lifetime pharmacy maximum per person
Prescription drugs (see the Prescription Drugs section)		
Mental health and substance abuse (see “Mental Health/Substance Abuse In and Out of Network” on page 92)		

¹ 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.

² 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 by cash or check, or with before-tax dollars if you have available funds in a Health Care Spending Account (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 123 and “Exclusions and Limitations” on page 145.

The CP500 is self-insured; therefore, Citi pays the claims incurred. The CP500 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 depend on whether the expense is covered by the plan and whether you choose a preferred provider or a non-preferred provider. Using preferred providers (in-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. *Citi plans only cover services that are deemed medically necessary.*

You must meet a deductible before the plan will pay benefits. Both in-network and out-of-network services will apply to meeting the deductible. Precertification is required before any inpatient hospital stay and certain outpatient procedures.

CP500 Network Features

Deductible

If you elect to use physicians or other providers in the network, you will need to meet an annual in-network deductible of \$500 individual/\$1,000 family before any benefit will be paid. Once you meet your deductible, the plan will pay 80% of covered in-network expenses.

The individual deductibles apply to all covered expenses except preventive care (which is covered at 100% in network), 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.

Deductible expenses cross-apply between in-network and out-of-network limits.

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 80% of certain covered expenses, your coinsurance for these expenses is 20%.

Medical Out-of-Pocket Maximum

The out-of-pocket maximum for medical 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 in-network services. This amount does not include penalties, charges above the MAA, prescription drug expenses or services not covered under CP500. Once this out-of-pocket maximum is met, covered medical expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator for the remainder of the calendar year. In-network copays for medical services also apply to the out-of-pocket maximums; once the out-of-pocket maximum has been satisfied, no additional in-network medical copays will apply for the remainder of the plan year. Prescription drug copays are subject to a separate out-of-pocket maximum.

Eligible medical 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 medical out-of-pocket maximum. Among those that do *not* count are:

- > Charges above MAA;
- > Penalties;
- > Prescription drug expenses (which count toward the separate prescription drug out-of-pocket maximum); and
- > Charges for services not covered under CP500.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum of \$1,500 individual/\$3,000 family, the plan pays the full cost of prescription drug expenses for the remainder of the year.

Out-of-pocket maximum expenses cross-accumulate between in-network and out-of-network limits.

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 CP500 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 POS II Open Access Plan, or call **1 (800) 545-5862**.
- > Anthem BlueCross BlueShield: **www.anthem.com**; to access a network provider through the BlueCross BlueShield Association BlueCard® PPO Program, select "Find a Doctor." 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 Anthem at **1 (855) 593-8123**.

- > If you live in Metro-New York; Washington, D.C./Maryland/Northern Virginia; Georgia; Kansas City, Missouri, or St. Louis, Missouri; Arizona; Florida; Tennessee, or New Jersey, you have access to an alternate network of providers. Please see your Anthem ID card to get the prefix you should use to search for providers on Anthem's website, or call Anthem's Health Guide Service Team for additional information about alternate networks and information on how to locate a participating provider.
- > Once you meet your deductible, the plan will pay 80% of covered in-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 80% of covered in-network expenses.

Allergist

When you see an in-network allergist, once you meet your deductible, you will be expected to pay 20% 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 you receive services other than an allergy injection, coinsurance will apply.

Preventive Care

Preventive care services are covered at 100% with no deductible to meet for the CP500. For additional information on what is considered to be preventive care, see "Medical Options at a Glance" on page 61.

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 and urinalysis;
- > Well-child services and routine pediatric care; and
- > Routine well-woman exams.

In addition, CP500 will cover both cancer-screening tests and well-adult and well-child immunizations performed by in-network providers at 100%, not subject to deductible. Routine cancer screenings are:

- > Pap smear performed by an in-network provider annually;
- > Mammogram;
- > Sigmoidoscopy;
- > Colonoscopy; and
- > Prostate-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 of the Centers for Disease Control and Prevention; and
- > Comprehensive Guidelines Supported by the Health Resources and Services Administration.

Routine Care

CP500 offers additional coverage for routine care services to help in the early detection of health problems.

- > Routine vision exam:
 - **In network:** Covered at 100%, not subject to deductible; one exam per calendar year, performed by a network ophthalmologist or optometrist;
 - **Out of network:** Covered at 100%, not subject to deductible, up to \$250 per calendar year;¹ then covered at 60% of MAA, not subject to deductible; limited to one exam per calendar year.

¹ Combined maximum with well-adult and well-child visits, routine cancer screenings and routine hearing care.

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:
 - **In network:** Covered at 100%, not subject to deductible; one exam per calendar year, performed by a network provider.
 - **Out of network:** Covered at 100%, not subject to deductible, up to \$250 per calendar year;¹ then covered at 60% of MAA, not subject to deductible; limited to one exam per calendar year.

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 80% 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 in-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

Services provided in a hospital emergency room from a network provider are covered at 80% for covered services after the deductible has been met.

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 precertification to use an urgent care center. Services provided by an urgent care center are covered at 80% 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. In-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 ID 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.

Charges Not Covered

An in-network provider contracts with the CP500 Claims Administrator to participate in the network. Under the terms of this contract, an in-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 in-network provider to pay any charges for services or supplies not covered under CP500 or not approved by CP500. In that case, the in-network provider may bill charges to you. However, these charges are not covered expenses under CP500 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 152 or "Claims and Appeals for Anthem BlueCross BlueShield Medical Plan" on page 160.

Paying Your Bill at Your In-Network Doctor's Office

After you meet your annual deductible, the plan will pay 80% for most covered services, while you will pay 20% of the plan's negotiated rate. In most cases, your doctor will bill you for the 20%. Generally, you will not pay your in-network doctor on the day of your visit because you will have to wait for your portion of the charge to be calculated.

Choosing In-Network Providers

CP500 is administered by Aetna and Anthem BlueCross BlueShield. When you enroll in the CP500, 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 POS II Open Access Plan, or call **1 (800) 545-5862**.
- > **Anthem BlueCross BlueShield:** www.anthem.com; to access an in-network provider through the BlueCross BlueShield Association BlueCard® PPO Program, select "Find a Doctor." 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 (855) 593-8123**.
- > If you live in metro New York; Washington, D.C./Maryland/Northern Virginia; Georgia; Kansas City, Missouri, or St. Louis, Missouri; Arizona; Florida; Tennessee; or New Jersey, you have access to an alternate network of providers. Please see your Anthem ID card to get the prefix you should use to search for providers on Anthem's website, or call Anthem's Health Guide Service Team for additional information about alternate networks and information on how to locate a participating provider.

Note: Before visiting an in-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 the CP500. These expenses generally are reimbursed at a lower level than in-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 152, or “Claims and Appeals for Anthem BlueCross BlueShield Medical Plan” on page 160.

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 (which is covered at 100% in network) 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 in-network/\$1,500 out-of-network individual deductible; or
- > **Three or more in a family:** Expenses can be combined to meet the \$1,000 in-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, CP500 normally pays 60% of the maximum allowed amount (MAA) for covered expenses that are received out of network. Providers may balance-bill you for the charges above MAA, and you are responsible for those charges.

Medical Out-of-Pocket Maximum

The out-of-pocket maximum for medical services rendered outside of the network is \$6,000 individual/\$12,000 family. This amount includes the \$1,500 individual/\$3,000 family deductible, coinsurance and copays, and represents the most you will have to pay out of your own pocket in a calendar year for medical services received outside the network, excluding charges that exceed MAA expenses, penalties, prescription drug expenses or services not covered under CP500. 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 medical out-of-pocket maximum. Among those that do *not* count are:

- > Expenses that exceed MAA;
- > Penalties;
- > Prescription drug expenses (which apply toward a separate prescription drug out-of-pocket maximum); and
- > Charges for services not covered under the plan.

To help you manage the high cost of prescription drugs, there is also a separate annual prescription drug out-of-pocket maximum. Once you reach the prescription drug out-of-pocket maximum of \$1,500 individual/\$3,000 family, the plan pays the full cost of prescription drug expenses for the remainder of the plan year.

In addition, expenses incurred when using in-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 60% 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 CP500 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 per calendar year, performed by an in-network ophthalmologist or optometrist; and
- > **Routine hearing exam:** Covered at 100%, not subject to deductible, one exam per calendar year, performed by an in-network otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 60% 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 semiprivate 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

Services provided in a hospital emergency room from an out-of-network provider are covered at 80% of MAA for covered services after the deductible has been met.

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 80% 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. In-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 ID 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, 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/Substance Abuse In and Out of Network

CP500 provides confidential mental health and substance abuse 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 substance abuse 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 80% of the negotiated rate.	After the deductible, eligible expenses are covered at 80% of the negotiated rate.
If you call the plan but do not use its network provider/facility	After the deductible, eligible expenses are covered at 60% of MAA.	After the deductible, eligible expenses are covered at 60% of MAA.

Coverage Levels

Mental health and substance abuse treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under CP500.

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

Inpatient Services

CP500 pays benefits at the in-network level (80% of the negotiated rate contracted with the Claims Administrator) if you call the plan, you use an in-network provider, and the treatment is medically necessary and occurs in the appropriate level-of-care setting. If you do not use an in-network provider, you will be reimbursed at 60% of MAA after the deductible is met, provided that the treatment is medically necessary and occurs 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 semiprivate 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 an in-network provider, you will be reimbursed at 80% of covered expenses after the deductible is met. If you do not use an in-network provider, you will be reimbursed at 60% 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 four 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 substance abuse treatment does not require a referral. However, you are encouraged to call the Claims Administrator within 48 hours after an emergency admission. The CP500'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* section for the definition of medical necessity.

For more information about what your plan covers, see "Covered Services and Supplies" on page 123. You may also contact your plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Concurrent Review and Discharge Planning

The following items apply if the CP500 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.

Anthem BlueCross BlueShield uses medical management guidelines developed by an internal team of physician medical directors, registered nurses and other clinical professionals, using data from a third-party organization, when determining these medical management services.

High Deductible Health Plan (HDHP)

The HDHP, administered by Aetna and Anthem BlueCross BlueShield, covers the same services as ChoicePlan 500 (CP500). However, there are certain major differences between the plans.

- > The HDHP provides flexibility and choice around how to spend your health care dollars. The HDHP is generally available at a lower premium cost, yet it has higher deductibles.
- > Prescription drugs count toward the individual/family deductible and out-of-pocket maximum. You do not need to meet a separate prescription drug deductible.
- > Participating in the HDHP gives you access to different accounts than other plans do.
- > 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, 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.

When you enroll in the HDHP, you must be prepared to spend the amount of your individual or family deductible out of pocket before the plan will pay benefits for non-routine care. As a reminder, certain preventive services/medications and routine cancer screenings are covered in full when you use in-network providers. 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 you are 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.

Want to Know More about How the HDHP and HSA Work?

Watch a short benefits video for helpful information.

HDHP at a Glance

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* section for a definition of MAA, which is sometimes referred to as “Recognized Charges.”

Type of Service	In-network	Out-of-network
Annual deductible (in-network and out-of-network services combined)		
<i>Single</i>	<ul style="list-style-type: none"> > \$1,800 > Includes prescription drug expenses 	<ul style="list-style-type: none"> > \$2,800 > Includes prescription drug expenses
<i>Family</i>	<ul style="list-style-type: none"> > \$3,600 > Includes prescription drug expenses 	<ul style="list-style-type: none"> > \$5,600 > Includes prescription drug expenses
Annual out-of-pocket maximum (includes deductible, medical/prescription drug coinsurance and medical/prescription drug copays)		
<i>Single</i>	<ul style="list-style-type: none"> > \$5,000 > Includes prescription drug expenses 	<ul style="list-style-type: none"> > \$7,500 > Includes prescription drug expenses
<i>Family¹</i>	<ul style="list-style-type: none"> > \$10,000 (\$6,850 per individual) > Includes prescription drug expenses 	<ul style="list-style-type: none"> > \$15,000 (\$15,000 per individual) > Includes prescription drug expenses
<i>Lifetime maximum</i>	None	None
Professional care (in office)		
<i>PCP visits</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Specialist visits</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Allergy treatment</i>	80% after deductible ²	60% of MAA after deductible ²
Preventive care (subject to frequency limits)		
<ul style="list-style-type: none"> > Well-adult visits and routine immunizations 	100%, not subject to deductible	100% of MAA, not subject to deductible
<ul style="list-style-type: none"> > Well-child visits and routine immunizations 		
<ul style="list-style-type: none"> > Routine cancer screenings (Pap smear, mammography, sigmoidoscopy, colonoscopy, PSA screening) 		
<i>Contraceptive devices</i>	100%, not subject to deductible, for diaphragms and Mirena, an implantable device, and at least one in each category of the other applicable forms of contraception in the FDA Birth Control Guide that are not covered under the Citi Prescription Drug Program (see “Preventive Care” beginning on page 67). All other implantable devices will be covered at 80% after deductible. ²	60% of MAA after deductible ²
<i>Voluntary sterilization — including tubal ligation, sterilization implants and surgical sterilizations</i>	100%, not subject to deductible. Male sterilization services (e.g., vasectomies) and abortions are covered at 80% after deductible. ²	60% of MAA after deductible ²

Type of Service	In-network	Out-of-network
Routine care (subject to frequency limits)		
<i>Routine vision exam</i>	100%, not subject to deductible; limited to one exam per calendar year	100% of MAA, not subject to deductible; limited to one exam per calendar year
<i>Routine hearing exam</i>	100%, not subject to deductible; limited to one exam per calendar year	100% of MAA, not subject to deductible; limited to one exam per calendar year
Hospital inpatient and outpatient		
<i>Semiprivate room and board, doctor's charges, lab, X-ray, radiology and surgical care</i>	80% after deductible; ² precertification required for hospitalization and certain outpatient procedures and services	60% of MAA after deductible; ² precertification required for hospitalization and certain outpatient procedures and services
Non-routine outpatient		
<i>Lab, X-ray and radiology</i>	80% after deductible; ² precertification required for certain outpatient procedures	60% of MAA after deductible; ² precertification required for certain outpatient procedures
Maternity care		
<i>Physician office visit</i>	80% after deductible ²	60% of MAA after deductible ²
<i>Hospital delivery</i>	80% after deductible ²	60% of MAA after deductible ²
Emergency care (no coverage if not a true emergency)		
<i>Hospital emergency room (includes emergency room facility and professional services provided in the emergency room)</i>	80% after deductible; ² precertification required if admitted	80% after deductible; ² precertification required if admitted
<i>Urgent care facility</i>	80% after deductible ²	80% of MAA after deductible ²
Emergency Transportation Services (no coverage when used as routine transportation to receive inpatient or outpatient services)		
<i>Ambulance</i>	<ul style="list-style-type: none"> > 80% after deductible² > Precertification required for air transport 	<ul style="list-style-type: none"> > 80% of MAA after deductible; precertification required for inter-facility transfers > Precertification required for air transport
Outpatient short-term rehabilitation		
<i>Physical/occupational therapy (combined)</i> Limited to 60 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	<ul style="list-style-type: none"> > 80% after deductible² > 70% after deductible² for visits approved for medical necessity above plan limits 	<ul style="list-style-type: none"> > 60% after deductible² > 50% of MAA after deductible² for visits approved for medical necessity above plan limits
<i>Speech therapy</i> Limited to 90 visits a year in-network and out-of-network combined; you may be eligible for additional visits with plan approval after a medical necessity review	<ul style="list-style-type: none"> > 80% after deductible² > 70% after deductible² for additional visits above plan limits 	<ul style="list-style-type: none"> > 60% after deductible² > 50% of MAA after deductible² for additional visits above plan limits

Type of Service	In-network	Out-of-network
Other services		
<i>Infertility treatment</i>	<ul style="list-style-type: none"> > Covered up to a \$24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 80% after deductible;² precertification required > Prescriptions covered through CVS Caremark up to a \$7,500 lifetime pharmacy maximum per person 	<ul style="list-style-type: none"> > Covered up to a \$24,000 per person lifetime medical maximum. The lifetime maximum will be coordinated among all non-HMO/PPO medical options. > 60% after deductible;² precertification required > Prescriptions covered through CVS Caremark up to a \$7,500 lifetime pharmacy maximum per person
Prescription drugs (see the <i>Prescription Drugs</i> section)		
Mental health and substance abuse (see “Mental Health/Substance Abuse In and Out of Network” on page 92)		

¹ The family deductible can be satisfied as a family or by an individual within the family. Each of your covered family members has an individual out-of-pocket maximum of only \$6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the \$10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the family's in-network health care expenses for the rest of the year.

² 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 by cash or check, or with before-tax dollars if you have available funds in an HSA.

HDHP Features

- > Most covered in-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 60% of the maximum allowed amount (MAA) after the deductible has been met. **Note:** Only your deductible, coinsurance and any copays — 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 in-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 in-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. (**Note:** Skin cancer screenings are not covered at 100%.) For frequency limits, please contact your plan at the number on the back of your ID card.
- > Other recommended preventive care services are covered at 100% when using in-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 CVS Caremark. You first must meet your combined medical and prescription drug deductible before you can purchase prescription drugs at a retail in-network pharmacy and through the CVS Caremark Home Delivery program for the plan's copay or coinsurance, except as described in the bullet immediately following.
- > You can purchase certain preventive care medications for a copay or coinsurance *before* the deductible is met. Copays/coinsurance count toward your out-of-pocket maximum. For a list of preventive medications, visit the CVS Caremark website. If you are a participant in a medical plan with prescription drug coverage through CVS Caremark, visit www.caremark.com.
- > The plan has no lifetime maximum benefit other than for infertility coverage and travel and lodging expenses related to transplant services.

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

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

- > Aetna: **www.aetna.com**; select the Aetna Open Access, Choice POS II Open Access Plan, or call **1 (800) 545-5862**.
- > Anthem BlueCross BlueShield: **www.anthem.com**; select the PPO, or call **1 (855) 593-8123**. (Note: If you live in Metro-New York; Washington, D.C./Maryland/Northern Virginia; Georgia; Kansas City, Missouri, or St. Louis, Missouri; Arizona; Florida; Tennessee; or New Jersey, you have access to an alternate network of providers. Please see your Anthem ID card to get the prefix you should use to search for providers on Anthem's website, or call Anthem's Health Guide Service Team for additional information about alternate networks and information on how to locate a participating provider.

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) coverage 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. Whether you visit an in-network provider or an out-of-network provider, your costs count toward both deductibles.

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:

- > **In Network**
 - **Employee Only:** The individual deductible of \$1,800 applies.
 - **Two or more in a family:** The \$3,600 family deductible applies; one family member 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 an in-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 family member 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 60% of MAA for claims for covered services submitted for an out-of-network provider. Providers may balance-bill you for the charges above MAA, and you are responsible for those charges.

Deductible expenses cross-apply between in-network and out-of-network limits.

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). Each of your covered family members has an individual out-of-pocket maximum of only \$6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. The amount includes the \$1,800/individual and \$3,600/family (out-of-network \$2,800/\$5,600) deductible, coinsurance and any medical copays. This represents the most you will have to pay out of your own pocket in a calendar year.

Only your deductible, coinsurance amount and any applicable medical copays — 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. Each of your covered family members has an individual out-of-pocket maximum of only \$6,850 for in-network coverage. After reaching that amount, your plan will cover 100% of that individual's in-network health care expenses for the rest of the year. Once the \$10,000 family in-network out-of-pocket maximum is met, your plan will cover 100% of the family's in-network health care expenses for the rest of the year. 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.

Out-of-pocket expenses cross-apply between in-network and out-of-network limits.

Preventive Care

Covered expenses are not subject to the deductible and are covered at 100% when using in-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;

- > Sigmoidoscopy;
- > Colonoscopy; and
- > Prostate-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 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 67.

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 calendar year; 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 calendar year.

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 an in-network provider; or
- > 60% 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 in-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 an in-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. In-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 ID 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.

Mental Health/Substance Abuse

The Aetna/Anthem BlueCross BlueShield HDHP provides confidential mental health and substance abuse 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 substance abuse 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 80% of the negotiated rate.	After the deductible, eligible expenses are covered at 80% of negotiated rate.
If you call the plan but do not use its network provider/facility	After the deductible, eligible expenses are covered at 60% of MAA.	After the deductible, eligible expenses are covered at 60% of MAA.

Coverage Levels

Mental health and substance abuse 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 possible 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 an in-network provider or 60% 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 semiprivate 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 an in-network provider, you will be reimbursed at 60% 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 four 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 substance abuse 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* section for the definition of medical necessity.

For more information about what your plan covers, see “Covered Services and Supplies” on page 123. You may also contact your plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Health Savings Accounts (HSAs)

An HSA is used in conjunction with a qualified High Deductible Health Plan (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 HDHP;
- > Have no other health coverage except what is permitted under “other health coverage”;
- > Not be enrolled in Medicare Parts A and B or Medicaid; and
- > Not be claimed as a dependent on someone else’s tax return.

Regardless of your insurance you may visit Citi’s on-site medical clinics for preventive care (health screenings and flu shots) and episodic care (if you are ill, have an emergency or accident at work or need non-prescription medications). You may also receive allergy injections if you have a prescription from your doctor and supply the allergy medications. Blood tests for monitoring health conditions with a prescription from your doctor can be done and will be billed to your insurance. Citi’s on-site medical clinics are not a replacement for your own primary care doctor. If you established an HSA, you may not use Citi’s on-site medical clinics for care that is considered impermissible. Examples of impermissible medical coverage include, but are not limited to: routine annual physical exams and ongoing treatment of chronic medical conditions.

Citi will contribute to your HSA if you:

- > Enroll in the HDHP for 2021;
- > Open a Citi HSA through 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 and when you establish an HSA. 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. Your HSA must be established by the following dates for you to be eligible for the Citi quarterly contributions.

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

Deadline to Receive Citi's Quarterly Contribution		Citi's Contribution for Employee Only Coverage	Citi's Contribution for Employee + Spouse/Children/Family Coverage
Q1	4 p.m. ET on 12/31/20	\$125	\$250
Q2	4 p.m. ET on 3/31/21	\$125	\$250
Q3	4 p.m. ET on 6/30/21	\$125	\$250
Q4	4 p.m. ET on 9/30/21	\$125	\$250

Note: To receive Citi's quarterly contribution, you must establish an HSA by accepting the terms and conditions, and satisfy Citi's policies and procedures requirements by the deadlines listed above.

The maximums that you can contribute to an HSA for 2021 are:

- > \$3,600¹ for an eligible individual with Employee Only coverage, and
- > \$7,200² for an eligible individual enrolling in any other coverage category.

¹ Includes Citi's annual employer contribution of up to \$500, if you open an HSA through ConnectYourCare.

² Includes Citi's annual employer contribution of up to \$1,000, if you open an HSA through ConnectYourCare.

Under federal law, individuals who are 55 or older by December 31, 2021, can make a catch-up contribution of an additional \$1,000 for 2021 and each year going forward.

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

Funds are available in the HSA once they have been contributed. This is different from the HCSA, where your entire elected contribution amount is available for reimbursement at the beginning of the plan year.

HSA 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 HDHP.
- > Contributions (subject to limits) and earnings are tax-free under federal and many state income tax laws.
- > Withdrawals (to pay for qualified medical, dental and vision expenses, as determined by the Internal Revenue Code [the "Code"]) are tax-free under federal and many state income tax laws.
- > Withdrawals can be used to pay for qualified medical, dental and vision expenses, as determined by the Code, for you and your tax dependents.
- > 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% on the disbursed amount that is not used for qualified health care expenses or health care expenses for dependents not considered as tax dependents under Section 152 of the Code.

Note: The HSA is not part of the Citigroup medical plans or any other employee benefits plan sponsored by Citi and it is not subject to ERISA.

Important COVID-19 Related Update

Under new IRS provisions, you can also use your HSA / HCSA or LPSA for COVID-19 personal protective equipment, such as masks, hand sanitizer and sanitizing wipes. You will need to manually reimburse yourself for these purchases by submitting a claim.

The HSA and the LPSA

If you enroll in the HDHP and make tax-free contributions to an HSA, you cannot participate in an HCSA. *HCSA enrollment is considered “impermissible medical care coverage” and disqualifies your contributions to an HSA.* According to IRS regulations, if you enroll in the HDHP, you can enroll in the 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” subsection 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.”

Fully Insured Health Maintenance Organizations (HMOs)

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

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 “2021 Insured HMOs” on page 109. There is a separate HMO Certificate of Insurance for each fully insured HMO.

- > The *Eligibility and Participation* section and the *Administrative Information* section 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 “2021 Insured HMOs” on page 109 or on your ID card.

For a list of the HMOs offered by Citi and the Certificate of Insurance for each HMO, see “2021 Insured HMOs” on page 109. 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 “2021 Insured HMOs” on page 109. 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 in-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. After you meet your deductible, the HMO will pay covered services at 80%, while you will pay 20% (your coinsurance). Your annual out-of-pocket maximum is \$3,000/individual and \$6,000/family.

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 and Health Plan HawaiiPlus (HMSA).

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 “2021 Insured HMOs” on page 109 for HMO contact information.

PCPs

In general, when you are a participant in an HMO, your PCP provides and coordinates all of your in-network care. In most cases, if you need to visit a specialist, your PCP will refer you to in-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 provider directories of the HMOs, which are listed under “2021 Insured HMOs” on page 109. 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 precertification from your HMO. Your PCP may help 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 (prostate-specific antigen) screenings;
- > Routine vision exams; and
- > Routine hearing exams.

Hospital Care

Generally, hospital care — both inpatient and outpatient — requires a copay or coinsurance. If you use an in-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 coordinate the approval.

See the HMO Certificate of Insurance listed under “2021 Insured HMOs” on page 109 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 covered 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 “2021 Insured HMOs” on page 109 for more information about maternity coverage.

Call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938** (see the *For More Information* section for detailed instructions, including TDD and international assistance) 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. However, if your 31 day notification period falls within the COVID-19 Outbreak Period, you will have an additional 31 days after the end of the Outbreak Period to make coverage changes.

Emergency Care

Benefits are always available in a medical emergency, whether you use in-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 copay for each emergency room visit. If you are admitted to the hospital, the copay is generally waived. Non-emergency services provided in an emergency room are not covered.

See the HMO Certificate of Insurance listed under “2021 Insured HMOs” on page 109 for more information, including your HMO’s definition of a true medical emergency.

Benefit Limits

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

2021 Insured HMOs

The following fully insured HMOs are offered by Citi for 2021 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
Health Plan Hawaii Plus (HMSA)	<ul style="list-style-type: none"> > 1 (808) 948-6372 > 1 (808) 948-5060 (Annual Enrollment information) > www.hmsa.com
Kaiser FHP of California — Northern	<ul style="list-style-type: none"> > 1 (800) 464-4000 > http://my.kp.org/citigroup
Kaiser FHP of California — Southern	<ul style="list-style-type: none"> > 1 (800) 464-4000 > http://my.kp.org/citigroup
SelectHealth (Utah and part of Idaho)	<ul style="list-style-type: none"> > 1 (800) 538-5038 > www.selecthealth.org

Live Well Chronic Condition Management Programs

If you are enrolled in a medical plan through Citi, you may be eligible to participate in a Live Well Chronic Condition Management Program through your medical carrier. If your health data indicates that you have a particular chronic condition, you may be contacted by a professional from your medical plan to participate in a specific program to address your chronic health conditions. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Aetna

Care Management is available to you and your dependents under the Aetna program. Aetna's Care Management program is focused on supporting all aspects of your care needs. You can speak with a nurse to support a whole range of issues such as diabetes, heart disease, cancer, low back pain and digestive conditions. Care Management can help you to:

- > Manage your condition;
- > Lower your risks for new conditions;
- > Work better with your doctor;
- > Take your medicine safely; and
- > Connect you with other resources available from both Citi and Aetna.

If you enroll in the Care Management program upon invitation, you will work directly with an Aetna nurse, who acts as a personal Advocate to you and your family. Depending on your situation, you may receive a call, text or letter from Aetna inviting you to participate.

Anthem BlueCross BlueShield

The Anthem BlueCross BlueShield Disease Management Program helps you maintain your health, improve your health outcomes and control health care expenses associated with the following prevalent conditions:

- > Asthma (pediatric and adult);
- > Diabetes (pediatric and adult);
- > Heart failure;
- > Coronary artery disease; and
- > Chronic obstructive pulmonary disease.

If you are enrolled in a Citi medical plan and you or a family member has diabetes, you can participate in Livongo's Diabetes Management Program (Livongo for Diabetes™). See "Other Health Management Programs" on page 114 for more information.

The Integrated Health Model (IHM)

The Integrated Health Model (IHM) offers personalized one-on-one support from a trained health professional who is dedicated to your needs. You can call your personal health consultant directly for questions about your family's health, assistance with setting health goals or help with a serious health concern. Your personal health consultant will also connect you to targeted programs and services that provide education, guidance and coaching for improved health outcomes.

Anthem Health Guide

Anthem Health Guide makes getting answers to your customer service and health-related questions easy and efficient. You can reach Anthem associates in the way that's most convenient for you — whether by telephone, online chat or secure email, or even by requesting a call back. Anthem will provide information and consultation, and will directly connect you to resources like health coaches, case managers or in-network doctors. Our goal is to guide you and your family to better health.

Centers of Excellence (COEs)

Centers of Excellence (COE) are top-rated facilities that meet or exceed rigorous, evidence-based criteria established in collaboration with expert physicians and medical organizations. These facilities demonstrate a history of achieving faster recovery times and better expected outcomes. Because facilities must reapply for the designation on a regular basis, you can be sure they provide consistently high-quality care. And high-quality care is more cost-effective care, because you'll experience fewer complications from your treatment.

Centers of Excellence are equipped to deliver complex medical care in specialties such as bariatric, orthopedic and transplant services. Due to the recognition of the importance of having certain specialized procedures performed only at top-rated facilities with a history of achieving faster recovery times and better-than-expected outcomes, the Citigroup Health Benefits Plan includes the following requirements:

- > Bariatric procedures will only be covered when performed at a COE.
- > Orthopedic and transplant procedures will be covered at the out-of-network level when received outside of a COE.

If you enroll in a medical plan through Aetna or Anthem BlueCross BlueShield, you'll have access to Centers of Excellence for certain conditions, referred to as "Aetna Institutes™" by Aetna and as "Blue Distinction Centers" by Anthem BlueCross BlueShield as described below.

Travel and Lodging Expenses

The plan will assist the patient and family with travel and lodging arrangements, when available, when a qualified transplant, bariatric or orthopedic procedure is medically necessary and performed at a designated Center of Excellence facility. **Expenses for travel and lodging** for the recipient and a companion are available as follows:

- > Transportation is covered, including expenses for personal car mileage at the current federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant, bariatric or orthopedic procedure for an evaluation, the 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, bariatric or orthopedic recipient resides more than 75 miles from the designated facility for Aetna or Anthem BlueCross BlueShield;

- > 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; and
- > These benefits are subject to a combined overall lifetime maximum of \$10,000 per covered person, per occurrence, for all transportation and lodging expenses incurred by the transplant, bariatric or orthopedic recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the plan in connection with all transplant, bariatric or orthopedic procedures.

Aetna Institutes™

The Aetna Institutes are a network of high-performing hospitals, clinics and health care facilities that offer specialized care. These institutes focus on bariatric, cardiac and orthopedic surgeries, as well as on transplant support and infertility services. Our members look for the Aetna Institutes name so they can receive high-quality care at a reasonable cost.

The types of Aetna Institutes are:

- > Institutes of Excellence™
- > Institutes of Quality®

Aetna Institutes of Excellence

Aetna Institutes of Excellence help patients who are facing a transplant or going through treatment for infertility. To be selected, a health care facility must maintain accreditation by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) and meet quality criteria for:

- > Number of procedures
- > Success rates
- > Cost-effective care
- > How often patients return to the hospital, and
- > Rates of complications.

IOE Transplant Support

The Institutes of Excellence (IOE) transplant network is Aetna's national network of facilities for transplants and transplant-related services. Hospitals that have been selected to participate in Aetna's IOE transplant network have met enhanced quality thresholds for volumes and outcomes. Facilities have been contracted on a transplant-specific basis and are considered to be participating only for the specific transplants for which they are contracted and have IOE designations.

The IOE transplant network was established to enhance quality standards and lower the cost of transplant care. Three criteria were applied with respect to network selection:

- > Enhanced organ-specific quality standards;
- > The national availability of and need for transplant facilities, on a transplant-specific basis. Need was assessed relative to the distribution of our membership and relative incidence of transplant types; and
- > Mutually acceptable contractual terms and conditions.

Transplants represent highly specialized care delivered by a limited number of providers who have expertise in performing these procedures. By utilizing an IOE transplant facility, you will be receiving treatment from a provider that has demonstrated experience and success in that specific transplant type. Facilities in the IOE transplant network meet Aetna quality standards for volumes and outcomes. IOE facilities also meet Aetna access standards and agree to mutually acceptable contractual terms and conditions.

Institutes of Quality

Aetna Institutes of Quality provide bariatric, cardiac and orthopedic procedures. We select hospitals that meet certain standards of quality and cost efficiency. We measure many factors, such as:

- > Patient satisfaction
- > Level of care, and
- > How often people return to the hospital after surgery.

Anthem Blue Distinction Centers

Anthem BlueCross BlueShield, in partnership with the Blue Cross and Blue Shield Association, has developed Blue Distinction Centers for treatment of serious medical conditions. Blue Distinction Centers are facilities that provide the highest quality of care in these specialties:

- > Bariatric surgery (inpatient and outpatient);
- > Transplants (bone marrow/stem cell, heart, lung, liver, pancreas);
- > Knee and hip replacement;
- > Spine surgery (discectomy, spinal fusion, spinal decompression);
- > Cardiac care (percutaneous coronary interventions, coronary artery bypass grafts); and
- > Complex and rare cancers.

The hospitals that are named as Blue Distinction Centers are chosen for a few reasons. They are known for their expert health care team, the number of times they have performed a procedure and their track record for results in specialized care. When you make important health care choices with your doctor, having access to the Blue Distinction Centers and Blue Distinction Centers+ makes these choices easier.

All Blue Distinction Centers offer quality specialty care. However, the new Blue Distinction Centers+ are honored for how cost-effectively they provide care.

To find a Blue Distinction Center, visit **www.anthem.com**:

- > Select “Find a Doctor”
- > Enter the type of health professional or hospital you are looking for and the location
- > Select “Recognition/Awards”

If a provider listed is a Blue Distinction Center, you will find a Blue Distinction recognition/award in the Quality Snapshot next to the provider’s name.

Other Health Management Programs

If you are enrolled in a medical plan through Citi, you may be eligible to participate in a variety of health management programs. The information that follows provides an overview of the available programs. Please contact your carrier for more details.

Citi Health Concierge

If you are enrolled in the ChoicePlan 500 or the HDHP, your Citi Health Concierge can provide personalized support and guide you to the right resources when you need them, so you get the most out of all of Citi's benefits — even if your question isn't specific to your medical coverage. When in doubt, start with your personal Citi Health Concierge as your first call.

Among the services Citi Health Concierge offers, it can help with:

- > Estimating medical costs, finding a doctor or getting a new medical ID card;
- > Support if you're diagnosed with a new medical condition;
- > Backup childcare or elder care referrals; and
- > If you are overwhelmed and need help finding resources.

You can contact your Citi Health Concierge by calling the phone number on your medical ID card.

Livongo for Diabetes™ Program

If you are enrolled in a Citi medical plan and you or a family member has diabetes, you can participate in Livongo's diabetes management program (Livongo for Diabetes™). The program offers three key components:

- > A connected glucose meter that transmits data and messaging in real time;
- > A smart analytics platform that provides predictive and personalized insights; and
- > Virtual coaching from Certified Diabetes Educators.

This approach encourages more frequent blood glucose checks, provides just-in-time outreach from Certified Diabetes Educators and automates the often-cumbersome task of ordering supplies and manually tracking blood glucose readings. Most importantly, participants receive personalized, real-time information that can enable more confident self-management and improved glycemic control.

Medical Specialty Drugs Administered by a Medical Provider

Aetna and Anthem will provide the following medical specialty medication programs to plan members:

Mandatory Site of Care Redirection Program

If you receive certain specialty drugs at an outpatient hospital facility, you may receive a letter from Aetna or Anthem about utilizing a lower level of care which meets your needs. This would include receiving your infusion in the office setting, an infusion center, or in the comfort of your home through a home infusion provider. If this affects you, Aetna or Anthem will work with you to transition your care to one of these settings, or call your Citi Health Concierge at the number on your medical ID card to learn more.

Precertification

Precertification is required for certain Medically Administered Specialty Drugs to help make sure proper use and guidelines for these drugs are followed. Your provider will submit clinical information which will be reviewed for decision. Aetna or Anthem will give the results of the decision to both you and your provider by letter.

For a list of Medically Administered Specialty Drugs that need precertification, please contact Aetna or Anthem at the number on your medical ID card. The precertification list is reviewed and updated from time to time. Including a Specialty Drug on the list does not guarantee coverage under your Plan. Your provider may check with Aetna or Anthem to verify Specialty Drug coverage, to find out which drugs are covered and if precertification is required.

If you are receiving an infused medication, certain medications may require use of the lowest cost site of care.

Site of Care Programs

Aetna's Site of Care program and Anthem's Right Drug Right Channel program target self-administered specialty drugs that can be best managed through the pharmacy benefit program rather than through the medical plan. If you are currently receiving a specialty drug which is on the drug list for this program through your medical benefit, you will need to get the drug through your pharmacy benefit.

If the drug you take is given as an injection, you will need to give the drug(s) to yourself and it will now be provided through your pharmacy benefit program. Your doctor or nurse can teach you or a caregiver how to give the injection. You can also ask your doctor to call the Provider Services number on your medical ID card and find out if a nurse can train you at home.

Aetna

Teladoc — Doctors on Demand

Teladoc provides access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. Teladoc does not replace the existing primary care physician, psychologist or therapist relationship, but enhances it as a convenient, affordable alternative for medical care.

Generally, you pay a \$40 copay subject to the deductible per Teladoc phone or video consultation with a physician, psychologist or therapist. After the deductible has been met, you will pay 20% of the consult, or \$8, per consult. Charges for phone or video consultations with a physician, psychologist or therapist and/or other provider who is not contracted with Aetna's Teladoc service are excluded.

Note that due to COVID-19, Teladoc visits with in-network providers are covered at 100% with no copay, and are not subject to the deductible until June 30 2021.

For more information, visit www.teladoc.com.

Personal Health Record

Employees and covered family members enrolled in a medical program with Aetna have access to a Personal Health Record, which scans your information and compares it with the latest medical guidelines to identify potential problems and send you alerts.

When you visit the doctor, have a test or fill a prescription, the claims information gets populated automatically into your Personal Health Record. You can add important information yourself too, such as:

- > Family health history;
- > Immunizations;
- > Doctors;
- > Allergies;
- > Blood pressure, weight, blood sugar and cholesterol numbers; and
- > Tests, procedures and more.

There are several ways the tool can help you:

- > **Share it with your doctor.** The “home page” of your Personal Health Record is the Health Summary. It’s your health information at a glance. You can decide what to share with your doctor. You can print out your Health Summary, take it with you to your doctor, or share it securely online before your visit.
- > **Keep track of when you are due for important checkups.** It can help remind you when to get preventive screenings, like a mammogram or colonoscopy.
- > **Track important health numbers.** See how your blood pressure, blood sugar, weight and other health markers change over time in clear, easy-to-understand graphs and charts.
- > **Manage your family’s health information.** The Personal Health Record is available to employees who enroll in an Aetna health benefits or health insurance plan. Covered family members have their own Personal Health Records. As the plan subscriber, you can access and add information to their Personal Health Records — as long as they are under age 18. You can give your covered spouse this access, too.

To get started, visit www.aetna.com and create a username and password on the secure member website. Then go to the Health Records tab and click on “Personal Health Record.”

Aetna Maternity Program

Aetna’s maternity management program is available to Aetna members and can be used throughout your pregnancy and after your baby is born. You’ll get information on:

- > Prenatal care;
- > Preterm labor symptoms;
- > What to expect before and after delivery; and
- > Newborn care and more.

All program materials are in English and Spanish. Translation services are also available in over 170 languages.

If you have health conditions or risk factors that could impact your pregnancy, you can work with a nurse case manager to help lower those risks. If eligible, you also get:

- > Two follow-up calls after your delivery;
- > A screening for depression; and
- > Extra support, if needed.

The Aetna Maternity Program also offers a Smoke-Free Moms-to-Be® program, where you'll get one-on-one nurse support to help you quit smoking for good.

To access the program, call 1 (800) CRADLE-1 (1 (800) 272-3531), weekdays from 8 a.m. to 7 p.m., ET, or log in to the secure member website at www.aetna.com and look under "Health Programs."

Aetna In Touch CareSM

Aetna's In Touch Care program gives you direct phone access to a registered nurse. Through this program, one nurse is assigned to you and any family members. This care is also available online. To register, visit www.aetna.com.

Aetna's Autism Advocate Program

Employees and their dependents have access to a designated Autism Advocate who is specifically trained in Autism Spectrum Disorder (ASD). The Autism Advocate is a dedicated single point of contact to help families affected by an autism diagnosis by:

- > Addressing questions about autism benefits;
- > Finding providers;
- > Overseeing Utilization Management (authorization) for applied behavior analysis (ABA);
- > Resolving claims issues;
- > Assuring that treatment is effective;
- > Connecting parents to all available resources; and
- > Coordinating with integrated autism care providers and supports.

Autism Clinical Requirements

- > There must be a diagnosis of Autism Spectrum Disorder;
- > The maladaptive target behavior must be severe (risk to personal safety, or the safety of others in the child's environment, or very significantly/completely interferes with ability to function);
- > Parent/caregiver(s) must be involved in training of behavioral techniques;
- > There is a time-limited, individualized treatment plan with objective measures that describes behavioral interventions;
- > There is involvement of community resources (such as the school district); and
- > Services must be provided by individuals licensed by the state or certified by the Behavior Analyst Certifying Board.

Anthem BlueCross BlueShield

Engage Wellbeing

Engage provides a one-stop shop for a seamless healthcare experience to managing your health plan from your phone, computer, or other mobile device.

Engage lets you access tools that will keep you connected to important health information 24/7. Think of Engage as your personalized health assistant. Visit **engage-wellbeing.com** and register in minutes to:

- > Get peace of mind. Clearly see what's covered by your plan, how much services will cost, where you've spent your health care dollars, and access your digital insurance card anytime, anywhere
- > Find doctors you'll love. Search ratings and reviews from real people, and find high-quality doctors or specialists in your network and near you
- > Make the most of your perks. Save time and money by discovering additional benefits and programs

Register for Engage at no cost at <https://engage.castlighthealth.com/v2/registration/e/citigroup> or just search for Engage Wellbeing in the App Store®

LiveHealth Online

LiveHealth Online provides access to a national network of U.S. board-certified doctors, pediatricians, psychologists or therapists who are available on-demand 24 hours a day, 7 days a week, 365 days a year to diagnose, treat and prescribe medication (when necessary) for many medical issues via phone or online video consultations. LiveHealth Online does not replace the existing primary care physician, psychologist or therapist relationship, but enhances it as a convenient, affordable alternative for medical care.

For 2021, you pay \$59 per LiveHealth Online phone or video consultation with a physician until the deductible is met. After that, you pay \$11.80 per consultation. Online visits with a therapist are \$80, with a psychologist are \$95 and with a psychiatrist are \$175 for the initial evaluation and \$75 for follow up visits, all applying to your medical plan deductible and coinsurance. Once you meet the annual out-of-pocket maximum, consultations are covered in full for the remainder of the year. If you are enrolled in an HSA or HCSA/LPSA, the fee is considered a qualified health care expense and can be reimbursed through your spending account. Charges for phone or video consultations with a physician, psychologist or therapist and/or other provider who is not contracted with Anthem's LiveHealth Online service are excluded. In most states, the physician can e-prescribe medications for you after a LiveHealth Online consultation if needed.

Note that due to COVID-19, LiveHealth Online visits with in-network providers are covered at 100% with no copay, and are not subject to the deductible until June 30, 2021.

For more information, visit **www.livehealthonline.com**.

Future Moms

Future Moms helps expectant mothers with routine to high-risk pregnancies focus on early prenatal interventions, risk assessments and education, leading to overall healthier outcomes for mothers and newborns. The program includes:

- > 24/7 phone access to a nurse coach who can talk with you about your pregnancy and answer your questions;
- > *Your Pregnancy Week by Week*, a book to show you what changes you can expect for you and your baby over the next nine months; and
- > Useful tools to help you, your doctor and your Future Moms nurse coach track your pregnancy and spot possible risks.

With Future Moms Breastfeeding Support on LiveHealth Online, you can have secure and private video chats with a certified lactation consultant, counselor or registered dietitian at no cost. These professionals will be able to provide personalized support to help you with breastfeeding techniques, including consultations about milk production, baby hunger cues, foods to avoid, postpartum nutrition and more. Sign up for free at **www.livehealthonline.com** or on the mobile app. You do not have to be enrolled in the Future Moms program to utilize this service.

Maternity Management

If you or one of your dependents is pregnant, the Maternity Management program can help you develop a guided course of care and treatment.

Neonatal Intensive Care Unit (NICU)

The program consists of inpatient, post-discharge and extended outpatient management by a NICU case manager with neonatal and/or pediatric nursing experience.

WINFertility

WINFertility is an industry leader in fertility management services whose foundation is built on value and delivering the highest quality fertility care. WIN will complete prior authorization of each treatment cycle available under your benefits. Through the program, you will have 24/7 access to WIN's Nurse care Manager who can answer your questions while considering your level of risk and the success rates of different treatment options, as well as listen to your concerns while you are trying to get pregnant. You can use the program to learn:

- > About infertility causes, testing and types of treatment;
- > About the types of drugs used for infertility treatment;
- > About the side effects, storage and proper usage of your fertility drugs;
- > How to select a provider;
- > How to find a high-risk maternity group and health plan programs to join; and
- > How to access Anthem's National Network of Reproductive Endocrinologists.

WINFertility assists Anthem members with managing their prescription drugs for fertility services.

WINFertility also provides 24/7 access to Nurse Care Managers who can answer your questions, help you find providers and listen to your concerns while you are trying to get pregnant.

For more information or if you have any questions call **1 (833) 204-2713** or go to <https://managed.winfertility.com/citi/>.

Transplant

If you're identified as a potential (or actual) transplant candidate, you will be referred to the transplant team. The transplant nurse will manage all of your care (inpatient, outpatient, home care, discharge planning, etc.) from the day of approval through six months post-transplant.

Behavioral Health Resource

Behavioral Health Resource includes a 24/7 Resource Center for you to call for assistance at any time, with care management programs for behavioral health and depression.

AIM Imaging Cost and Quality Program

Anthem BlueCross BlueShield has partnered with AIM Specialty Health to offer access to important information about imaging services you might need.

If you need an MRI or a CT scan, it's important to know that costs can vary quite a bit depending on where you go to receive the service. Sometimes the differences are significant — anywhere from \$300 to \$3,000 — but a higher price does not guarantee higher quality. Your benefits require you to pay a portion of the cost (through deductible and coinsurance), so where you go can make a very big difference to your wallet. AIM does the research and makes it available to help you find the right location for your MRI or CT scan. Here's how the program works:

- > Your doctor refers you to a radiology provider for an MRI or CT scan.
- > AIM works with your doctor to help make sure that you are receiving the right test — using evidence-based guidelines.
- > AIM also reviews the referral to see if there are other providers in your area that are high quality but have a lower price than the referred one.
- > If AIM finds another provider that meets the quality and price criteria, AIM will give you a call to let you know.
- > You can choose which radiology provider you wish to perform the service. AIM will even help you schedule an appointment with the new provider.

Sleep Study Program

The Plan includes benefits for a Sleep Management Program, administered by AIM Specialty Health, which is a program that helps your doctor make better-informed decisions about your treatment for sleep-related issues. The Sleep Management Program includes outpatient and home sleep testing and therapy. If you require sleep testing, depending on your medical condition, you may be asked to complete the sleep study in your home. Home sleep studies provide the added benefit of reflecting your normal sleep pattern while sleeping in the comfort of your own bed versus going to an outpatient facility for the test.

As part of this program, you are required to get precertification for:

- > Home sleep tests (HST);
- > In-lab sleep studies (polysomnography or PSG, a recording of behavior during sleep);
- > Titration studies (to determine the exact pressure needed for treatment); and
- > Treatment orders for equipment, including positive airway pressure devices (APAP, CPAP, BPAP, ASV), oral devices and related supplies.

If you need ongoing treatment, AIM will review your care quarterly to assure that medical criteria are met for coverage. Your equipment supplier or your doctor will be required to provide periodic updates to ensure clinical appropriateness. Ongoing claim approval will depend partly on how you comply with the treatment your doctor has ordered.

Please talk to your doctor about getting approval for any sleep testing and therapy equipment and supplies.

Autism Spectrum Disorder (ASD) Program

The ASD Program is a specialized, dedicated team of clinicians within Anthem who have been trained on the unique challenges and needs of families with a member who has a diagnosis of ASD. Anthem provides specialized case management services for members with Autism Spectrum Disorder and their families. The program also includes precertification and medical necessity reviews for applied behavior analysis, a treatment modality targeting the symptoms of Autism Spectrum Disorder.

For families touched by ASD, Anthem's Autism Spectrum Disorder Program provides support for the entire family, giving assistance wherever possible and making it easier for families to understand and utilize care — resulting in access to better outcomes and more effective use of benefits. The ASD Program has three main components:

Education

- > Educates and engages the family on available community resources, helping to create a system of care around the member; and
- > Increases knowledge of the disorder, resources and appropriate usage of benefits.

Guidance

- > Applied behavior analysis management, including clinical reviews by experienced licensed clinicians. Precertification delivers value, ensuring that the member receives the right care, from the right provider, at the right intensity. ABA therapy is covered, subject to deductible and coinsurance, in accordance with Anthem's clinical policy.
- > Increased follow-up care encouraged by appointment setting, reminders, attendance confirmation, proactive discharge planning and referrals; and
- > Assures that parents and siblings have the best support to manage their own needs.

Coordination

- > Enhanced member experience and coordination of care;
- > Assistance in exploration of medical services that may help the member, including referrals to medical case management; and
- > Licensed behavior analysts and program managers provide support and act as a resource to the interdisciplinary team, helping them navigate and address the unique challenges facing families with an autistic child.

Trouble Sleeping?

Keep in mind that Citi also offers Sleepio, a leading app-based, online sleep improvement program that is scientifically proven to help you fall asleep and stay asleep. This service is free to all Citi employees, regardless of whether you are enrolled in a Citi medical plan. However, your spouses/partners must be enrolled in a Citi medical plan to utilize Sleepio's services. If you are considering the Sleep Study Program, using Sleepio first may provide information that will assist in your assessment in the Sleep Study Program. Learn more about Sleepio online at www.sleepio.com/livewell, or email your questions to Sleepio customer service at hello@sleepio.com.

Primary Nurse

Primary Nurse serves as a personal health guide for individuals and their families. Each personal nurse provides education, counseling, tools and support to help you navigate the health care system and make wise decisions. Primary Nurse is available if you are experiencing health issues or need assistance managing lifestyle issues. Primary Nurse primarily uses the following:

- > Coaching for education and self-care via web-based self-help tools and the program's 24/7 NurseLine;
- > Collaborative goal planning and intervention strategies;
- > Facilitation, coordination and referral to necessary services;
- > Incorporating clinical resources such as pharmacists, social workers and dietitians; and
- > Mailed and telephonic education, including healthy living support through the Healthwise Knowledgebase®.

The program also offers you and any covered family members one-on-one support by phone from a health coach with strategies to help with:

- > Losing weight;
- > Getting ready for surgery; and
- > Lowering stress levels and more.

The coach works with you and your family to create an individualized program care plan that features personalized goals to ensure you are following your provider's plan of care.

24/7 NurseLine

You may have emergencies or questions for nurses around the clock. 24/7 NurseLine provides you with accurate health information at any time of the day or night. Through one-on-one counseling with experienced nurses available 24 hours a day via a convenient toll-free number, you can make more-informed decisions about the most appropriate and cost-effective use of health care services. A staff of experienced nurses is trained to address common health care concerns such as medical triage, education, access to health care, diet, social/family dynamics and mental health issues. Specifically, the 24/7 NurseLine features:

- > A skilled clinical team, including an RN-licensed nurse (BSN preferred), that helps you assess symptoms and understand medical conditions, ensures you receive the right care in the right setting, and refers you to programs and tools appropriate to your condition;
- > Bilingual RNs, language line and hearing-impaired services;
- > Access to the Audio Health Library, containing hundreds of audiotapes on a wide variety of health topics;
- > Proactive callbacks within 24 to 48 hours if you are referred to 911 emergency services or poison control, and for pediatric members with needs identified as either emergent or urgent; and
- > Referrals to relevant community resources.

Covered Services and Supplies

This list of covered services and supplies applies to all ChoicePlan 500 and High Deductible Health Plan 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, a sickness or a pregnancy. Reimbursement for all covered services and supplies listed in this section is subject to the maximum allowed amount (MAA) or, for in-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, copays and deductibles will apply to these services.

Acupuncture

Acupuncture must be administered by a medical doctor or a licensed acupuncturist (if state license is available).

Aetna: Acupuncture is covered for the following:

- > Pain management, treatment for nausea related to pregnancy, and postoperative and chemotherapy-induced nausea and vomiting;
- > Chronic low back pain (maintenance treatment, where the patient's symptoms are neither regressing nor improving, is considered not medically necessary; if no clinical benefit is appreciated after four weeks, then the treatment plan should be re-evaluated);
- > Migraine headache;
- > Pain from osteoarthritis of the knee or hip (adjunctive therapy; if no clinical benefit is appreciated after four weeks, then the treatment plan should be reevaluated);
- > Postoperative dental pain; and
- > Temporomandibular disorders (TMD).

Anthem: Acupuncture is covered, with no visit limits or diagnosis requirements.

Acupuncture is covered if administered by a medical doctor, an osteopathic physician, a chiropractor or a licensed acupuncturist (if state license is available).

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 for those at risk; for those at risk, two doses at least six months apart;
- > **Hepatitis B:** Immunize if age 46 or under; if over age 45, only for 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 for those at risk); if at 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:** Males and females age 9 years to 26 years (age restrictions do not apply to Anthem BlueCross BlueShield); and
- > **Zostavax vaccine for shingles:** Adults age 60 or older.

Ambulatory Surgical Center

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

Anesthetics

Anesthetics are 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.

Autism Assistance Benefits

If you enroll in an Anthem or Aetna medical plan, family members who have been diagnosed with Autism Spectrum Disorder have access to autism assistance benefits, including applied behavior analysis (ABA) therapy.

Members diagnosed with Autism Spectrum Disorder (ASD) have coverage available for the diagnosis and treatment of ASD, when ordered by a physician, licensed psychologist or licensed clinical social worker as part of a treatment plan.

Baby Care

The following services and supplies may be 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.

Note: If the newborn child is discharged at the same time as the mother, then the charges for the services rendered for the child are subject to coinsurance only. The mother's claims are subject to the deductible and coinsurance. If the newborn child remains in the hospital longer than the mother, the claims for the child apply to his or her own deductible and coinsurance limits if the member has not already met the family limits.

Note: If your covered dependent child gives birth, only the services for your dependent child are covered. Your newborn grandchild is not eligible for coverage.

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;
- > Prostate-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 Anthem 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.

Gene Therapy Services

Anthem BlueCross BlueShield: The Plan includes benefits for gene therapy services, when Anthem approves the benefits in advance through precertification. To be eligible for coverage, services must be medically necessary and performed by an approved provider at an approved treatment center. Even if a provider is an in-network provider for other services it may not be an approved provider for certain gene therapy services. Please call Anthem Member Services to find out which providers are approved providers. (When calling Member Services, ask for the transplant case manager for further details.)

Your Plan does not include benefits for services determined to be experimental/investigational or services provided by a non-approved provider or at a non-approved facility.

Hearing Aids

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

- > **Adults:** Once every three calendar years.
- > **Children:** Once every two calendar years.

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 prescribed by a physician to keep the patient comfortable while in hospice care;
- > Part-time nursing care by or supervised by an 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.

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.

Anthem BlueCross BlueShield: You are eligible for hospice care if your doctor and hospice medical director certify that you are terminally ill and likely have less than twelve (12) months to live. You may access hospice care while participating in a clinical trial or continuing disease modifying therapy, as ordered by your treating provider. Disease modifying therapy treats the underlying terminal illness.

The services and supplies listed below are covered services when given by a hospice for the palliative care of pain and other symptoms that are part of a terminal disease. Palliative care means care that controls pain and relieves symptoms, but is not meant to cure a terminal illness. Covered Services include:

- > Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care.
- > Short-term Inpatient hospital care when needed in periods of crisis or as respite care.
- > Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse.
- > Services and counseling services from a licensed social worker.
- > Nutritional support such as intravenous feeding and feeding tubes.
- > Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist.
- > Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies.
- > Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the member's death. Bereavement services are available to surviving members of the immediate family for one year after the member's death. Immediate family means your spouse/partner, children, stepchildren, parents, brothers and sisters.

Hospital Services

Aetna and Anthem BlueCross BlueShield: 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 be 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, 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 (or 96 hours as applicable). Authorizations are required for longer stays.

Infertility Treatment and Cryopreservation

Treatment of infertility must be precertified. Penalties apply if the treatment is received without precertification.

In order to be eligible for fertility benefits you must be a covered employee, spouse/partner or eligible dependent ("covered person") under a Citi medical plan

- > 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 toward the medical lifetime fertility maximum.
- > Comprehensive infertility services benefits:
 - Ovulation induction
 - Intrauterine insemination
- > Advanced reproductive technology (ART) benefits:
 - In vitro fertilization (IVF) cycles, including freeze-all cycle (fertilization and culture of embryo)
 - Reciprocal IVF cycles
 - Intrauterine embryo lavage
 - Embryo transfer
 - Elective single embryo transfer
 - Artificial insemination
 - Gamete intrafallopian tube transfer (GIFT)
 - Zygote intrafallopian tube transfer (ZIFT)
 - Low tubal ovum transfer
 - Assisted hatching
 - Pre-implantation genetic diagnosis (PGD) and screening (PGS), when it is medically necessary (subject to medical criteria)
 - Evaluation by a reproductive endocrinologist or infertility specialist, drug therapy, and intracytoplasmic sperm injection (ICSI)
 - Cryopreserved embryo transfers
 - Oocyte (Egg) thaw cycles
 - ART services for procedures that are covered expenses including charges associated with storage and procurement of partner's sperm for ART and Testis Biopsy, when the partner is also covered under the Plan
 - Sperm sourcing includes specialized sperm retrieval techniques (including vasal sperm aspiration, microsurgical epididymal sperm aspiration (MESA), percutaneous epididymal sperm aspiration (PESA), electroejaculation, testicular sperm aspiration (TESA), microsurgical testicular sperm extraction (TESE), seminal vesicle sperm aspiration and sperm recovery from bladder or urine for retrograde ejaculation are considered medically necessary to overcome anejaculation or azoospermia)
- > Cryopreservation
 - Medically Necessary: Cryopreservation of sperm, oocytes or embryos is considered medically necessary for members undergoing infertility due to chemotherapy, pelvic radiotherapy or other gonadotoxic therapies, with no storage time limitation when approved and covered under the plan. Gonadotoxic treatments include chemotherapy, radiation, conditions, and surgical resection (for treatment of disease or gender affirmation treatment).
 - For IVF: All cryopreservation services are provided for members undergoing IVF.
 - Elective: Cryopreservation of oocytes when being done electively and not for medical reasons is covered, but the storage limitation will be for the 1st year and the cost of this service will apply to the infertility lifetime maximum.

> Exclusions:

- Infertility services, except as described under Covered Services.
- The plan does not cover charges for the storage of cryopreserved embryos or oocytes after the first year, or storage of sperm unless medically necessary.
- Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs. Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program.
- Third-Party Donors: The purchase of donor sperm and any charges for the storage of sperm; the purchase and storage of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier.
- Reversal of sterilization surgery.

Medical expenses for infertility treatment are covered up to a covered person's lifetime maximum of \$24,000. Only expenses for elective cryopreservation, advanced services (e.g., IVF, GIFT, ZIFT) and comprehensive services (e.g., artificial insemination) accumulate toward the lifetime maximum.

Expenses for diagnosis and treatment of the underlying medical condition do not count toward the lifetime maximum.

Prescription drug expenses associated with infertility treatment and elective cryopreservation are covered up to a lifetime maximum of \$7,500 per covered person under the Plan, as outlined in the "Prescription Drug" section.

HMOs

Each HMO offers different infertility coverage and limits, if they offer any such coverage at all. Check with your HMO for details of infertility coverage.

Intensive Outpatient Program

Structured, multidisciplinary behavioral health treatment that provides a combination of individual, group and family therapy in a program that operates no less than 3 hours per day, 3 days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Laboratory Tests/X-rays

X-rays or tests for diagnosis or treatment.

Please note following related to COVID-19 diagnostic testing:

Lab tests related to COVID-19

- > In-Network – Anthem/Aetna will waive copay, coinsurance, and deductible for the diagnostic test related to COVID-19 effective March 13, 2020.
- > Out-of-Network – Anthem/Aetna will waive copay, coinsurance, and deductible for the diagnostic test related to COVID-19. Pay up to network allowance and negotiate up to provider's posted amount effective March 13, 2020 for Anthem; March 6, 2020 for Aetna

Licensed Counselor Services

Services of a licensed counselor for mental health and substance abuse 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:

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- > 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;
- > 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; and
 - **Aetna:** Blood, blood products, processing, storage and administration. Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology and cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. **Note:** Routine harvesting and storage from stem cells from newborn cord blood is not covered. However, Aetna covers stem cells for hematopoietic cell transplant when deemed medically necessary according to the following criteria: Aetna considers compatibility testing of prospective donors who are close family members (first-degree relatives [i.e., parents, siblings and children] or second-degree relatives [i.e., grandparents, grandchildren, uncles, aunts, nephews, nieces, half-siblings]) and harvesting and short-term storage of peripheral stem cells or bone marrow from the identified donor medically necessary when an allogeneic bone marrow or peripheral stem cell transplant is authorized by Aetna.
 - Aetna considers umbilical cord blood stem cells an acceptable alternative to conventional bone marrow or peripheral stem cells for allogeneic transplant.
 - Aetna considers medically necessary the short-term storage of umbilical cord blood for a member with a malignancy undergoing treatment when there is a match. **Note:** The harvesting, freezing and/or storing of umbilical cord blood of non-diseased persons for possible future use is not considered treatment of disease or injury. Such use is not related to the person's current medical care.
 - **Anthem BlueCross BlueShield:** Blood, blood products, processing, storage and administration. Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees (typing, serology, cross-matching and blood storage) are also reimbursable. However, transportation charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood and blood product administration services are reimbursable only on an outpatient basis when billed hourly or at a flat rate with total eligible charges capped at the average approved semiprivate room rate.

The use of umbilical cord blood progenitor cell transplantation is considered medically necessary for selected individuals when all of the following criteria are met:

- One or two donor cord unit(s) are used for a single recipient;
- The total nucleated cell (TNC) count is equal to or greater than 2.3×10^7 per kg; and
- The umbilical cord blood stem cell unit(s) is used for an allogeneic stem cell transplant for an approved indication and the appropriate stem cell transplant criteria are met.

Collection and storage of cord blood is considered medically necessary only when an allogeneic transplant is imminent for an identified recipient and the above criteria are met. Storage will only be authorized at centers approved by one of the following accreditation bodies:

- Foundation for Accreditation of Cellular Therapy (FACT);
- National Cancer Institute (NCI);
- AABB (formerly known as American Association of Blood Banks); and
- California Department of Public Health.

Investigational and Not Medically Necessary: The use of umbilical cord blood progenitor cell transplantation is considered investigational and not medically necessary when it does not meet the criteria listed above.

Prophylactic collection and storage of umbilical cord blood is considered investigational and not medically necessary when proposed for an unspecified future use for an autologous stem cell transplant in the original donor or for an unspecified future use as an allogeneic stem cell transplant in a related or unrelated donor.

Medical Transportation Services

Covered expenses for ground ambulance include charges for transportation:

- > To the first hospital where treatment is given in a medical emergency;
- > From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- > From hospital to home or to another facility when medically necessary according to health plan clinical guidelines;
- > From home to hospital for covered inpatient or outpatient treatment when medically necessary according to health plan clinical guidelines; and
- > When during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air Transportation

- > Air ambulance requiring a transport to a hospital or from one hospital to the nearest hospital because:
 - A covered member is injured/stricken by illness more than 200 miles from their home, and
 - Need for care is determined by the current ordering provider to be longer than seven days, and
 - Need for care meets the utilization review criteria completed by the Aetna or Anthem clinical team, and
 - A commercial flight is deemed as not medically appropriate.

In-network ambulances should be utilized in all circumstances, network permitting.

Air ambulance is not covered for transport that is:

- > Directly to the covered member's home residence,
- > For short-term illness or injury (less than seven days of ongoing inpatient medical care needed),
- > For illness or injury not requiring ongoing covered inpatient medical care/rehabilitation stay,
- > For custodial services or any care that does not meet medical requirements for coverage,
- > For location less than 200 miles from home region, or
- > The current facility determines the covered member is not stable to travel.

In extremely rare occasions, exceptions may be made based on the Medical Director discretion.

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 125.

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;
- > 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.

- > **Anthem 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.

Organ/Tissue Transplants

Keep in mind that qualified transplant procedures will be covered at the out-of-network level when performed at a facility that is not deemed a Center of Excellence (COE) or Blue Distinction Center (BDC) through BlueCross BlueShield. Contact your plan for more information about locating a COE (or BDC).

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.
- > **Anthem BlueCross BlueShield** and **Aetna** do not require precertification within a certain number of 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 cells 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 and Anthem BlueCross BlueShield** cover 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 (CP500 and HDHP), a transplant will be covered as an in-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.

The National Medical Excellence (NME) Program® will coordinate all solid organ, bone marrow and CAR-T and T-cell therapy services, and other specialized care you need.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. While your transplant care is being coordinated by the NME Program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the covered service is not directly related to your transplant.

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 **Anthem BlueCross BlueShield**, coverage is based on the facility used for the transplant. If a Blue Distinction Center (BDC or BDC+) is used, the service will be covered at 80% with access to the travel and lodging benefit. Blue Distinction Centers 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 Anthem at **1 (855) 593-8123** for additional coverage information as well as assistance in locating a BDC or BDC+ facility.

Precertification is required for these services. Services performed at BDC or BDC+ facilities are covered at 80% with access to the travel and lodging benefit; all other facilities are covered at 60% with no access to the travel and lodging benefit. If care at a BDC or BDC+ facility requires you to travel 75 miles or more from your home, you’ll have access to a travel and lodging benefit, with a maximum of \$10,000 per surgery or treatment.

Medical Care and Treatment

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

- > Pre-transplant evaluation for one of the procedures listed above;
- > Organ acquisition and procurement;
- > Hospital and physician fees;
- > Transplant procedures;
- > Follow-up care for a period of up to one year after the transplant;
- > Search for bone marrow/stem cells 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., semiprivate room and board in an acute hospital setting) and a postoperative global period.

When available, the plan will assist the patient and family with travel and lodging arrangements when a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility. **Expenses for travel and lodging** for the transplant recipient and a companion are available as follows:

- > Transportation, including expenses for personal car mileage at the current federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant procedure 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 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 75 miles from the designated facility for Aetna or BlueCross BlueShield ;
- > 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;
- > These benefits are subject to a combined overall lifetime maximum of \$10,000 per covered person, per occurrence, 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.

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.

Orthopedic Surgery

Keep in mind that qualified orthopedic procedures will be covered at the out-of-network level when performed at a facility that is not deemed a Center of Excellence (COE) or a Blue Distinction Center (BDC or BDC+) through BlueCross BlueShield. Contact Member Services at your health carrier for more information about locating a COE (or BDC).

Qualified Procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility, the “medical care and treatment” and “transportation and lodging” provisions described in this section apply.

- > Total knee replacement;
- > Total hip replacement; and
- > Spine surgery (discectomy, spinal fusion, spinal decompression).

When available, the plan will assist the patient and family with travel and lodging arrangements when a qualified procedure, listed in this section, is medically necessary and performed at a designated Center of Excellence facility. **Expenses for travel and lodging** for the orthopedic recipient and a companion are available as follows:

- > Transportation, including expenses for personal car mileage at the current federal rate of reimbursement, of the patient and one companion who is traveling on the same day(s) to and/or from the site of the orthopedic procedure for an evaluation, the orthopedic 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 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 orthopedic recipient resides more than 75 miles from the designated facility;
- > 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;
- > These benefits are subject to a combined overall lifetime maximum of \$10,000 per covered person, per occurrence, for all transportation and lodging expenses incurred by the orthopedic recipient and companion (companions, if the covered dependent is a minor) and reimbursed under the plan in connection with all orthopedic procedures.

For **Anthem BlueCross BlueShield**, coverage is based on the facility used for the transplant. If a Blue Distinction Center (BDC or BDC+) is used, the procedure will be covered at 80%. Blue Distinction Centers meet stringent clinical criteria, established in collaboration with expert physician panels and national medical societies and are subject to periodic re-evaluation as criteria continue to evolve. Call Anthem at **1 (855) 593-8123** for additional coverage information as well as assistance in locating a BDC or BDC+ facility.

Precertification is required for these services. Services performed at BDC or BDC+ facilities are covered at 80% benefit; all other facilities are covered at 60%. If care at a BDC or BDC+ facility requires you to travel 75 miles or more from your home, you'll have access to a travel and lodging benefit, with a maximum of \$10,000 per surgery or treatment. There is no travel and lodging benefit for services rendered outside of a Blue Distinction Center.

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 under-converge or over-converge. 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 138.

Outpatient Physical Therapy

See "Rehabilitation Therapy" on page 138.

Partial Hospitalization Program:

Structured, multidisciplinary behavioral health treatment that offers nursing care and active individual, group and family treatment in a program that operates no less than six hours per day, five days per week. Out-of-Network Facility-based Programs must occur at Facilities that are both licensed and accredited.

Prescribed Drugs

Prescribed drugs and medicines for inpatient services.

Preventive Care

Covered expenses include:

- > Routine physical exam (including a well-woman exam), subject to frequency limits;
- > Routine immunizations;
- > Smoking cessation; and
- > Screening and counseling for obesity for adults and children.

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

For more specific information regarding what is considered to be Preventive Care, see "Preventive Care" on page 67.

Private-Duty Nursing Care (combined with Home Health Care)

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

- > **Aetna CP500 and Anthem BlueCross BlueShield CP500:** A combined in-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.

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 (when required by state law); 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 (including Down syndrome).

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 in-network and out-of-network services, wherever the services are being provided, for example, at home, at a therapist's office or in a free-standing therapy facility.
- > **CP500 and HDHP:** Spinal manipulation therapy is limited to 20 visits per calendar year. Physical and occupational therapies combined are limited to 60 visits per calendar year. Speech therapy is limited to 90 visits per calendar year.

Routine Care

Covered expenses include:

- > Vision exam once per calendar year; and
- > Hearing exam once per calendar year.

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

Residential Treatment Center/Facility

A provider licensed and operated as required by law, which includes:

- > Room, board and skilled nursing care (either an RN or LVN/LPN) available on-site at least eight hours daily with 24-hour availability;
- > A staff with one or more doctors available at all times;
- > Residential treatment that takes place in a structured facility-based setting;
- > The resources and programming to adequately diagnose, care and treat a psychiatric and/or substance use disorder;

- > Facilities that are designated residential, subacute or intermediate care and may occur in care systems that provide multiple levels of care; and
- > Is fully accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the National Integrated Accreditation for Healthcare Organizations (NIAHO) or the Council on Accreditation (COA).

The term Residential Treatment Center/Facility does not include a provider, or that part of a provider, used mainly for:

- > Nursing care;
- > Rest care;
- > Convalescent care;
- > Care of the aged;
- > Custodial care; and
- > Educational care.

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 138.

Spinal Manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means of structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this plan.

Surgery

Services for surgical procedures.

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. Plan deductibles, coinsurance and copays 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 Anthem BlueCross BlueShield cover assistant surgeon services for certain surgeries. Aetna covers registered nurses acting as assistant surgeons for certain surgeries. Contact Anthem 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 rate or MAA.
- > Second procedure: The plan will allow 50% of the negotiated rate or MAA.
- > Third and additional procedures: The plan will allow 50% of the negotiated rate or MAA for each additional procedure.
- > Bilateral and separate operative areas: The plan will allow 100% of the negotiated rate or MAA for the primary procedure, 50% of the negotiated rate or MAA for the secondary procedure, and 50% of the negotiated rate 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.

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.

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.

Transgender Benefits

Transgender benefits are covered under the Plan. The way the coverage is administered varies slightly between the carriers. This section describes specific coverage details for Aetna and Anthem BlueCross BlueShield.

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

- > Member is at least 18 years old;
- > 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;

- 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 two years that are not limited to periods of stress;
 - Absence of physical inter-sex or genetic abnormality;
 - Does not gain sexual arousal from cross-dressing;
 - Lifelong sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood;
 - 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.
- > 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 and estimates its frequency and duration throughout the real-life experience (usually a minimum of three 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.

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 and are not covered. Similarly, chin implants, nose implants and lip reduction, which have been used to assist masculinization, are considered cosmetic and are not covered.

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

- > The individual is at least 18 years of age;
- > The individual has capacity to make fully informed decisions and consent for treatment; and
- > The individual has been diagnosed with gender dysphoria and exhibits 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;
 - The transsexual identity has been present persistently for at least two years;
 - The disorder is not a symptom of another mental disorder; and
 - The disorder causes clinically significant distress or impairment in social, occupational or other important areas of functioning.
- > For individuals without a medical contraindication, the individual 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
- > Documentation** is provided showing that the individual has completed a minimum of 12 months of successful, continuous full-time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends and community members (for example, at school, work and other settings); and
- > The individual has undergone regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and
- > If the individual has significant medical or mental health issues present, they are reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, or borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and
- > Two referrals from qualified mental health professionals* who have independently assessed the individual are presented. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request for their submission.

* At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W. or Psy.D.) or a master's-level degree in a clinical behavioral science field (for example, M.S.W., L.C.S.W., Nurse Practitioner [N.P.], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Counselor [L.P.C.], or and Marriage and Family Therapist [M.F.T.]) 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 specifications set forth above.

** The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

Note: Gender affirmation surgery may include any of the following procedures:

- > Male-to-female procedures
 - Orchiectomy;
 - Penectomy;
 - Vaginoplasty;
 - Clitoroplasty; and
 - Labiaplasty.
- > Female-to-male procedures
 - Hysterectomy;
 - Salpingo-oophorectomy;
 - Vaginectomy;
 - Metoidioplasty;
 - Scrotoplasty;
 - Urethroplasty;
 - Placement of testicular prostheses; and
 - 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 affirmation 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 affirmation surgery:
 - Reduction thyroid chondroplasty;
 - Liposuction;
 - Rhinoplasty;
 - Facial bone reconstruction;
 - Face-lift;
 - Blepharoplasty;
 - Voice modification surgery;
 - Hair removal/hairplasty; and
 - Breast augmentation.

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:

- > Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
 - 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 an in-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;
- > 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;
 - 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 to health outcomes for these conditions.
- > Biofeedback, except as specifically approved by the Claims Administrator;
- > Blood, blood plasma and blood derivatives other than those described under "Covered Services and Supplies" on page 123.
- > 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 it is 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 123;
- > Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for Aetna or Anthem BlueCross BlueShield);
- > Coverage for an otherwise eligible person or a dependent who is on active military duty, including health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- > Custodial care consisting of the following:
 - 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 himself or herself or another caregiver can be or is being trained to care for the patient;

- > 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 123 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, and caffeine or nicotine use) problems and learning disabilities are not covered by the plan; see “Covered Services and Supplies” on page 123 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 charged by interns, residents, house physicians or other health care professionals who are employed by the covered facility, which makes their services available;
- > 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; and
 - That the Claims Administrator has determined, based on scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. See the *Glossary* section for the definition of experimental, investigational or unproven services;
- > Eyeglasses and contact lenses (**Anthem BlueCross BlueShield** 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 or metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and precertified 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, appliances 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 123;
- > Herbal medicine, holistic or homeopathic care, including drugs:
 - **Aetna:** Not covered; however, discounts are available through the Aetna Natural Products and Services Discount Program;
 - **Anthem BlueCross BlueShield:** Not covered; however, discounts on alternative medicine and treatment are available through the Anthem Special Offers Program. Log in to Anthem's website at www.anthem.com and click on "Discounts" for information about the Anthem Special Offers Program;
- > Household equipment including, but not limited to, the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypoallergenic pillows, mattresses or waterbeds, equipment or supplies to aid sleeping or sitting, and the removal from your home, workplace or other environment of carpeting, hypoallergenic pillows, mattresses, paint, mold, asbestos, fiberglass, 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.
- > The plan does not cover charges for the storage of cryopreserved embryos or oocytes after the first year, or storage of sperm unless medically necessary.
- > Covered services do not include the costs associated with surrogate mothers and the costs of donating donor eggs or services rendered to a non-covered member. Payment for charges associated with the care of an eligible covered person under this plan who is participating in a donor IVF program.

- > Third-Party Donors: The purchase of donor sperm and any charges for the storage of sperm; the purchase and storage of donor eggs and any charges associated with care of the donor required for donor egg retrievals or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier.
- > Reversal of sterilization surgery.
- > Inpatient private-duty or special nursing care. Outpatient private-duty nursing services must be precertified by the Claims Administrator;
- > Membership costs for health clubs, personal trainers, massages, weight loss clinics and similar programs;
- > Naturopathy;
- > Nutritional counseling and nutritionists except as described under “Covered Services and Supplies” on page 123;
- > 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;
- > 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 municipal, 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;
- > **Aetna:** Transplant services:
 - Services and supplies furnished to a donor when the recipient is not a covered person
 - Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
 - Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- > **Anthem:** 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; and
 - Urine auto-injections;
- > 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:
 - **Aetna:** Covered through Teladoc;
 - **Anthem:** Covered through LiveHealth Online;
- > 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;
- > **Aetna:** Treatment of spinal disorder:
 - Care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body;
 - Other physical treatment of any condition caused by or related to neuromusculoskeletal disorders of the spine, including manipulation of the spine;
 - 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 or other physical treatment of any condition caused by or that has to do with biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically covered in the plan;
- > 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 (CP500) and the High Deductible Health Plan (HDHP), 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 and Anthem BlueCross BlueShield 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 in-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 substance abuse 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. Claims are processed and applied toward deductibles when appropriate in the order in which they are received from providers. **Note:** This can differ from the order of the date of services.

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. ¹

Type of Claim	Timeline after Claim Is Filed
Preservice claims (for services requiring precertification of services)	<p>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)</p> <p>Notice that more information is needed must be given within five days.</p> <p>You have 45 days to submit any additional information needed to process the claim.¹</p>
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	<p>Decision made within 72 hours</p> <p>Notice that more information is needed must be given within 24 hours.</p> <p>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.</p>
Concurrent care claims (for ongoing treatment)	<p>Decision made within 24 hours for urgent care treatment</p> <p>Decision made sufficiently in advance for all other claims</p>

¹ The time period allowed to make a decision is suspended pending receipt of additional information.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

If your deadline to file a claim or appeal falls within the Agencies' deadline, you will have additional time to submit your claim.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form, or call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 for additional help.

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**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 and Appeals for Aetna Medical Plans" 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 period 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 (Preservice 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 preservice claim. You will be notified of the decision not later than 15 days after receipt of the preservice 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 preservice 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 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 preservice claims that name a specific claimant, medical condition, and service or supply for which approval is requested, and that are submitted to an Aetna representative responsible for handling benefit matters, but that otherwise fail to follow the plan's procedures for filing preservice claims, you will be notified of the failure within five 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 precertification 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 of, reduction of, 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 basis, 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 preservice claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or 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 preservice 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 preservice 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, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to begin suit is specified in an insurance contract forming part of the Plans or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

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 that 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 five business days following the date of receipt of the request, Aetna must provide a preliminary review determining that 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), 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: **1 (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-day 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 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 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 them 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 time frame 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 time frame 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.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

If your deadline to file an external review of your denied claims falls within the Agencies' deadline, you will have additional time to submit your claim.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form, or call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 for additional help.

Claims and Appeals for Anthem BlueCross BlueShield Medical Plan

The Plan wants your experience to be as positive as possible. There may be times, however, when you have a complaint, problem, or question about your Plan or a service you have received. In those cases, please contact Member Services by calling the number on the back of your Identification Card. The Claims Administrator will try to resolve your complaint informally by talking to your provider or reviewing your claim. If you are not satisfied with the resolution of your complaint, you have the right to file an appeal, which is defined as follows:

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 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.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

If your deadline to file a claim or appeal falls within Agencies' deadline, you will have additional time to submit your claim.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form, or call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 for additional help.

The Claims Administrator will review requests for benefits according to the timeframes listed below. The timeframes and requirements listed are based on Federal laws. You may call the phone number on the back of your Identification Card for more details.

Type of Review	Timeframe Requirement for Decision and Notification
Urgent Pre-service Review	72 hours from the receipt of request
Non-Urgent Pre-service Review	15 calendar days from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received more than 24 hours before the end of the previous authorization	24 hours from the receipt of the request
Urgent Continued Stay/Concurrent Review when request is received less than 24 hours before the end of the previous authorization or no previous authorization exists	72 hours from the receipt of the request
Non-urgent Continued Stay/Concurrent Review for ongoing outpatient treatment	15 calendar days from the receipt of the request
Post-Service Review	30 calendar days from the receipt of the request

If more information is needed to make a decision, the Claims Administrator will tell the requesting provider of the specific information needed to finish the review. If the Claims Administrator does not get the specific information needed by the required timeframe, the Claims Administrator will make a decision based upon the information it has.

The Claims Administrator will notify you and your provider of its decision as required by Federal law. Notice may be given by one or more of the following methods: verbal, written, and/or electronic.

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., preservice, concurrent, post-service, urgent, etc.).

For preservice 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:

Anthem BCBS
PO Box 105568
Atlanta, GA 30348

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, 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 preservice 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 under "Appeals" on page 161.

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 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 preservice 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:

Anthem BCBS
PO Box 105568
Atlanta, GA 30348

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.

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If your deadline to file a claim or appeal falls within the Agencies' deadline, you will have additional time to submit your claim.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form, or call the Citi Benefits Center via ConnectOne at 1 (800) 881-3938 for additional help.

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 benefits plan is sponsored by your employer and is 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.