Prescription drugs

Express Scripts manages the Citigroup Prescription Drug Program for participants in the ChoicePlan 500, High Deductible Health Plan, and Oxford PPO. The Citigroup Prescription Drug Program is a component of the Citigroup Health Benefit Plan.

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

Express Scripts covers FDA (Food and Drug Administration)-approved (federal legend) medications that require a prescription from your physician. Effective January 1, 2014 the plan will also cover certain OTC products in compliance with federal Health Care Reform rules. If you have any questions about whether a medication is covered, call Express Scripts at **1-800-227-8338** or check online at **https://member.express-scripts.com/preview/citigroup2014**.

Express Scripts offers three ways to purchase prescription drugs:

1. Through a network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection
2. Through the Express Scripts Home Delivery program where you may save money by having your maintenance and preventive drugs delivered by mail; and
3. Through Accredo Health Group (Accredo) previously known as CuraScript for specialty medications after the first two prescriptions are filled at a retail pharmacy. For third and future refills, you must use Accredo.

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

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Prescription drug benefits at a glance

PRESCRIPTION DRUG BENEFITS			
	ChoicePlan 500	**High Deductible Health Plan***	**Oxford PPO**
Annual deductible (network and out-of-network combined in ChoicePlan 500 and Oxford PPO)			
Individual	$100 per person (prescription drug deductible)	$1,800 network/$2,800 out of network; includes medical expenses	$100 maximum (prescription drug deductible)
Maximum per family	$200 family maximum (prescription drug deductible)	$3,600 network/$5,600 out of network; includes medical expenses (no benefits will be paid to an individual until the family deductible has been met)	$200 family maximum (prescription drug deductible)
Copayment for up to a 34-day supply at a network pharmacy after you meet your deductible. You may have the same maintenance prescription filled up to three times at a retail pharmacy; on the fourth fill, you will pay 100% of the cost of the medication.**			
> Generic drug***	$5		
> Preferred brand-name or formulary drug****	$30		
> Non-preferred brand-name or non-formulary drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150		
> Oral contraceptives (hormonal and emergency)	**Generics:** not subject to annual deductible, and no cost to you **Brand name drugs:** subject to the annual deductible and applicable preferred or non-preferred cost share requirement **Note:** If you cannot take generics, brand-name drugs will be available at no cost to you if you receive prior approval (your provider must provide evidence that you cannot take generics)		
Copayment for a 90-day supply through the Express Scripts Home Delivery program after you meet your deductible			
> Generic drug***	$12.50		
> Preferred brand-name or formulary drug****	$75		
> Non-preferred brand-name or non-formulary drug	50% of the cost of the drug with a minimum payment of $125 to a maximum of $375		

PRESCRIPTION DRUG BENEFITS			
	ChoicePlan 500	**High Deductible Health Plan***	**Oxford PPO**
> Oral contraceptives (hormonal and emergency)	**Generics:** not subject to annual deductible, and no cost to you **Brand name drugs:** subject to the annual deductible and applicable preferred or non-preferred cost share requirement **Note:** If you cannot take generics, brand-name drugs will be available at no cost to you if you receive prior approval (your provider must provide evidence that you cannot take generics)		
Copayment for a 30-day supply of specialty medication through the Accredo Specialty Pharmacy after you meet your deductible*****			
> Generic drug***	$5		
> Preferred brand-name or formulary drug****	$75		
> Non-preferred brand-name or non-formulary drug	50% of the cost of the drug with a minimum payment of $50 to a maximum of $150		
> Benefits at an out-of-network pharmacy	50% of your cost after you meet the deductible; you must file a claim for reimbursement		

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

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

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

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

***** Except in case of an emergency, each prescription for specialty medications can be filled only twice through a retail pharmacy. For third and future refills, you are required to fill the prescription through Accredo.

Note: For the ChoicePlan 500 and Oxford PPO, pharmacy and/or Express Scripts Home Delivery copayments do not count toward your medical plan's annual deductible or out-of-pocket maximum at out-of-network pharmacies:

> **For non-emergencies:** You will be reimbursed for 50% of the covered drug cost after the applicable deductible when a claim is filed.

> **For emergencies:** Reimbursement for all but the network copayment may be available. Please call Express Scripts at **1-800-227-8338**.

Retail network pharmacies with Express Scripts

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

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

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

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

- Ask your pharmacist;
- Visit **www.express-scripts.com** and on the left hand side of the homepage select the "Locate a pharmacy" option and enter your zip code or city and state and click on locate pharmacy; or
- Call Express Scripts at **1-800-227-8338** and follow the prompts for the retail pharmacy locator.

A network pharmacy will accept your prescription and prescription drug ID card and, once you have met your deductible, charge the appropriate copayment/coinsurance for a covered drug. Your copayment/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the Express Scripts Preferred Formulary, or a non-preferred brand-name drug. If you purchase a drug that is not covered under the plan, you will pay 100% of the full, non-discounted price of the drug. See "Drugs not covered" on page 167 for more information.

'Dispense as written'

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

Send all completed claim forms to:

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

Using your prescription drug ID card

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

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

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

In either case, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed. To access a claim form, visit Citi Benefits Online at **www.citibenefitsonline.com** and select "Claim forms."

Meeting your deductible

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

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

Express Scripts Home Delivery

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

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

When you use Express Scripts Home Delivery:

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

Obtaining a refill of a maintenance medication with Express Scripts

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

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

Specialty medication with Express Scripts

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

Accredo offers the following:

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

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

Exclusive Accredo

Citi participates in the Exclusive Accredo program, which means that, except in the case of an emergency, you can fill a prescription for a specialty medication only twice through a retail pharmacy. After that, the pharmacy will reject the prescription and you will be required to fill it through Accredo.

In the event of an emergency, you are permitted to fill the prescription more than twice at a retail pharmacy. You will continue to be charged only the applicable retail/specialty copayment.

Controlled substances with Express Scripts

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

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

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

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

How the Controlled Substance Processing works:

Controlled Substance Restrictions:

- The FDA does not allow refills on Class II controlled substances. A new prescription must be presented each time the medication is filled.
- The FDA requires presentation of a hardcopy on Class II prescriptions. They cannot be phoned or faxed into ANY pharmacy.
- The FDA mandates that prescriptions for Class III – Class V medications must be expired 6 months from the date that they are written. Note that some states have stricter laws that Express Scripts Pharmacy follows.
- Express Scripts Pharmacy fills all controlled medications out of its St. Louis facility. There is a very stringent verification process that takes place. The pharmacist reviews the actual hardcopy against the system entry prior to releasing for fulfillment.
- Special Requirements for Controlled Substance Processing:
- Controlled Substances require very specific information to be present on the prescription in order to be processed by Express Scripts. In the majority of cases the information required is missing upon original receipt of prescriptions.
- **A hand signature** is required on all prescriptions for controlled substances. Any controlled prescription with an electronic or missing signature requires pharmacy outreach to physician.
- **A valid DEA number** is required on all controlled substance prescriptions. If the DEA number is present, technicians must validate the DEA number. If the DEA number for the prescribing physician is NOT present or is invalid, pharmacy outreach to the physician is required.
- **A physical address on file** is required for all controlled substances. A physical address must be obtained if the address on the prescription or in our system is a PO Box.
- **A medical reason** is required for any Class II prescriptions being dispensed **over a 30 day** supply regardless of the state where the prescription is issued. A medical reason can either be a diagnosis or a detailed description. For example, "chronic pain" would not be sufficient, but "cervical pain unresolved by surgery" or "stabilized ADHD" would be sufficient. Going off to college is not an acceptable medical reason.

Process for Making Outreach:

- A **technician** is responsible for making the necessary outreach to the physician's office or to the patient by phone, fax, or electronic communication.
- The prescriber's office or patient has **2 business days** to respond. If clarification is obtained, the prescription image will **be annotated** and the prescription will continue along in the processing. If not received, the script will be routed to the interventions team who will make additional attempts to contract the physician and or patient for resolution.

Generics Preferred with Express Scripts

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

If you choose the brand-name drug where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.* See "'Dispense as written'" on page 161 for more information.

Prior authorization with Express Scripts

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

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

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

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

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

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

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

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

High Deductible Health Plan information

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

For a list of these preventive medications, call Express Scripts at **1-800-227-8338**. You can also visit **www.express-scripts.com**.

If you are enrolled in an HMO or are not enrolled in Citi coverage and you are considering enrolling in the High Deductible Health Plan, visit **https://member.express-scripts.com/preview/citigroup2014** to view the list of preventive medications. On the home page scroll to "High Deductible Health Plan Preventive Drug List" for a link to the list.

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

Covered drugs

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

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

Some drugs require prior authorization, such as (this list is not all inclusive):

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

HEALTH CARE REFORM

In compliance with Health Care Reform, beginning January 1, 2014 certain prescribed drugs are covered at 100%, not subject to deductible, if certain conditions are met. Certain dosage and other restrictions apply. If conditions are not met, OTC drugs are not covered and generic drugs are subject to the applicable copay or deductible.

	Conditions
Aspirin (to prevent cardiovascular disease)	> Generic OTC > Men ages 45 to 79 years and women ages 55 to 79 years old
Bowel Preps	> Generic OTC & Generic Prescription Drugs > Men and women ages 50 to 75 years old
Contraceptive Methods for Women	> Generic barrier methods (diaphragm and cervical cap) > Generic hormonal contraceptives > Generic emergency contraceptives > Prescribed OTC generic contraceptives (except condoms or other men's contraceptives)
Fluoride (generic oral formulations)	> Generic OTC & Generic Prescription Drugs > Children 6 months of age through 5 years of age
Folic Acid	> Generic OTC & Generic Prescription Drugs > Women through age 50
Iron Supplements	> Generic OTC & Generic Prescription Drugs > Children ages 6 to 12 months
Smoking Cessation	> Generic OTC & Generic Prescription Drugs, plus brand Chantix > Adults age 18 and over
Vitamin D	> Generic OTC & Generic Prescription Drugs > Adults age 65 and over

Step therapy

A Step Therapy program is a "step" approach to providing prescription drug coverage. Step Therapy is designed to encourage the use of cost-effective prescription drugs when appropriate. To determine if your prescription requires Step Therapy, or is subject to limitations, call Express Scripts at **1-800-227-8338**. If you have a discontinuance or lapse in therapy of more than 130 days while using the brand-name medication and need to restart therapy, you will be subject to another review under the Step Therapy program to determine if the cost of the brand-name medication will be covered under the Plan. There is no minimum age requirement for Step Therapy.

Here's how Step Therapy works:

1. A member presents a prescription for a drug requiring step therapy at a retail pharmacy or via Home Delivery.
2. The pharmacist enters the prescription information into the Express Scripts information ("ESI") system.
3. The claim is submitted for processing – the ESI system automatically looks back at the member's claim history to see if the member had a prescription filled in that time period for the alternative drug (130 days).
4. If a claim for an alternative drug is found, the claim will automatically process.
5. If there is no history of a prescription filled for an alternative drug, the prescription claim is rejected.

6. The pharmacist can either contact the member's physician to see if an alternative drug is acceptable or advise the member to contact his/her physician.
7. The physician can provide a prescription for an alternative drug. If the physician strongly feels that the original drug prescribed will best treat the member's condition, then he/she can submit a prior authorization request. If the request meets the clinical criteria, the originally prescribed drug will be covered.
8. A notification will be sent to both the member and physician on whether the request has been approved or denied.

Call Express Scripts at **1-800-227-8338** or **www.Express-Scripts.com** to obtain information on if your medication requires step therapy and/or the applicable copay for the generic, preferred brand or non-preferred category of drug.

Other limits

Coverage limits apply to some categories of drugs. These categories include but are not limited to:

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

Drugs not covered

The following drugs and products are not covered under the Citigroup Prescription Drug Program. Employees will pay 100% of the full, non-discounted price of these drugs. This list is not exhaustive and there may be other drugs that are not covered. For a list of covered alternatives for select medications listed below, visit **https://member.express-scripts.com/images/pdf/2014prefdrugexclusionlist.pdf**:

- Abbott Meters & Strips (Freestyle, Precision);
- Advair Diskus/HFA;
- Alvesco;
- Apidra;
- Auvi-Q;
- Avinza;
- Bayer Meters & Strips (Breeze, Contour);
- Beconase AQ;
- Betaseron;
- Bravelle;
- Breo Ellipta;
- Cimzia;
- Edarbi/Edarbyclor;
- Exalgo;
- Flovent Diskus/HFA;
- Follistim AQ;

- Fortesta;
- Jentadueto;
- Kadian;
- Kazano;
- Levitra;
- Maxair Autohaler;
- Micardis/Micardis HCT;
- Nesina;
- Nipro Meters & Strips (TRUEtrack, TRUEtest);
- Novolin;
- NovoLog;
- Nutropin/Nutropin AQ;
- Omnaris;
- Omnitrope;
- PegIntron;
- Proventil HFA;
- Relenza (this exclusion applies only to Express Scripts Home Delivery; prescriptions for Relenza are covered if filled at a retail pharmacy);
- Rhinocort Aqua;
- Roche Meters & Strips (Accu-Chek);
- Saizen;
- Simponi;
- Staxyn;
- Stelara;
- Tamiflu;
- Testim;
- Teveten/Teveten HCT;
- Tev-Tropin;
- Tradjenta;
- Veramyst;
- Victoza;
- Xeljanz;
- Xopenex HFA;
- Zetonna;
- Zioptan;
- Non-federal legend drugs;
- Prescription drugs for which there are OTC equivalents available, including, but not limited to, benzoyl peroxide, hydrocortisone, meclizine, ranitidine, and Zantac;
- Contraceptive implants:
  - **Note:** Implantable devices such as Mirena or Norplant are covered under the Citigroup Health Benefit Plan (not under the Citigroup Prescription Drug Program portion of the Plan);

- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Gardasil and Zostavax (vaccinations are covered under the Citigroup Health Benefit Plan; therefore, the provider must bill accordingly);
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices and appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or are for cosmetic purposes only (e.g., Renova®);
- Allergy serums;
- Biologicals, blood or blood plasma products;
- Drugs labeled "Caution — limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers' Compensation or occupational disease law or any state or governmental agency or medication furnished by any other drug or medical service for which no charge is made to the member;
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended-care facility, skilled nursing facility, convalescent hospital, nursing home, or similar institution that operates as, or allows to be operated as, a facility for dispensing pharmaceuticals on its premises;
- Any prescription refilled in excess of the number of refills specified by the physician or any refill dispensed after one year from the physician's original order; and
- Charges for the administration or injection of any drug.

Claims and appeals for Express Scripts

The amount of time Express Scripts will take to make a decision on a claim will depend on the type of claim.

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

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

Claim forms may be obtained by visiting Citi Benefits Online at **www.citibenefitsonline.com** or at **www.express-scripts.com**. These forms tell you how and when to file a claim.

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

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

Express Scripts first-level appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claims Administrator in considering the claim; and that demonstrates the Claims Administrator's processes for ensuring proper, consistent decisions.

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

You will be provided written or electronic notification of the decision on your appeal as follows:

- For appeals of preservice claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for the appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first-level appeal decision.
- For appeals of post-service claims, the first-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for the appeal of a denied claim. The second-level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first-level appeal decision.

Express Scripts second-level appeal

If you are not satisfied with the first-level appeal decision of the Claims Administrator, you have the right to request a second-level appeal from the Claims Administrator as the Plan Administrator. Your second-level appeal request must be submitted to the Claims Administrator within 60 days from receipt of first-level appeal decision.

For preservice and post-service claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding. **Note:** The Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Express Scripts urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

For urgent claim appeals, Citi has delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

MCMC external claim 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 have the right to file a request for an External Review with the plan if the request is filed within four months after the date of receipt of this notice of an adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following receipt of this notice. To request this appeal, use the contact information below:

MCMC LLC
ERISA Appeal Team
Express Scripts Appeal Program
300 Crown Colony Drive, Suite 203
Quincy, MA 02169

Telephone: **1-800-652-4840**
Fax: **1-800-882-4715**