Prescription Drugs

CVS Caremark manages the Citigroup Prescription Drug Program (Program) for participants in the In-Network Only Plan, Choice Plan (formerly known as the “ChoicePlan 500") and High Deductible Plan with HSA (formerly known as the “High Deductible Health Plan”). The Citigroup Prescription Drug Program is a component of the Citigroup Health Benefits Plan.

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

CVS Caremark covers Food and Drug Administration (FDA)-approved (federal legend) medications that require a prescription from your physician. The Program will also cover certain over-the-counter (OTC) products in compliance with the Affordable Care Act and as amended by the Setting Every Community Up for Retirement Enhancement Act. If you have any questions about whether a medication is covered, call CVS Caremark Customer Care at **1 (844) 214-6601**.

CVS Caremark offers three ways to purchase prescription drugs:

1. Through a comprehensive national network of nearly 68,000 retail pharmacies nationwide (a variety of chain and independent pharmacies, such as CVS retail stores, including those within a Target retail store), where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection;
2. Through the CVS Caremark Mail Service or Maintenance Choice® program, where you may save money by having your maintenance and preventive drugs (up to a 90-day supply, plus refills if appropriate) either delivered by mail or picked up at a CVS pharmacy store; and
3. Through the CVS Caremark Specialty Pharmacy, you must use the CVS Specialty Pharmacy.

You will pay a deductible, as shown in “Prescription Drug Benefits at a Glance” on page 161, for drugs purchased at a retail pharmacy, through Mail Service or Maintenance Choice, or through the CVS Specialty Pharmacy before the Program will pay benefits. *You will never pay more than the cost of the drug.*

Contents

Prescription Drug Benefits at a Glance

	Prescription Drug Benefits		
	In-Network Only Plan	**Choice Plan**	**High Deductible Plan with HSA[1]**
Annual deductible **Choice Plan:** In-network and out-of-network expenses combined count toward meeting your annual deductible. .			
Individual	$100 per person (prescription drug deductible)		$1,800 in-network/$2,800 out-of-network; includes medical expenses
Maximum per family	$200 family maximum (prescription drug deductible)		$3,600 in-network/$5,600 out-of-network; includes medical expenses (no benefits will be paid to an individual until the family deductible has been met)
Annual out-of-pocket maximum **In-Network Only Plan:** Annual prescription drug out-of-pocket maximum includes prescription deductible, copays and prescription coinsurance. This is separate from the annual medical out-of-pocket maximum. **Choice Plan:** Annual prescription drug out-of-pocket maximum includes prescription deductible, prescription coinsurance and prescription copays. In-network and out-of-network expenses are combined. This is separate from the annual medical out-of-pocket maximum. Eligible prescription 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 ($1,500) to the family out-of-pocket maximum ($3,000). **High Deductible Plan with HSA:** Prescription drug expenses count toward the medical annual out-of-pocket maximum Keep in mind, you will still pay 100% of the prescription cost after the out-of-pocket maximum is met after the third fill of a maintenance prescription at a non-CVS pharmacy.			
Individual	$1,500 per person (prescription drug out-of-pocket maximum)		$5,000 in-network/$7,500 out-of-network Includes both medical and prescription drug expenses
Maximum per family	$3,000 family maximum (prescription drug out-of-pocket maximum)		$10,000 ($6,850 per individual) in-network/ $$15,000 ($15,000 per individual) out-of-network Includes both medical and prescription drug expenses
Copay/coinsurance — in-network retail pharmacy Copay/coinsurance for up to a 31-day supply at an **in-network retail pharmacy (including Target pharmacies)**, after you meet your deductible. You may have the same maintenance prescription filled up to three times at a non-CVS pharmacy; on the fourth fill, you will pay 100% of the cost of the medication. However, maintenance medication will be available through a CVS pharmacy or through Mail Service for your 90-day copay.[2]			
Generic drug[2]	$10		
Preferred brand-name drug[3]	$30		
Non-preferred brand-name drug	50% of the cost of the drug, with a minimum payment of $50, to a maximum of $150. If the cost of the drug is less than $50, you will pay the cost of the prescription drug.		
Certain preventive care drugs as required under ACA	**Generics and Single Source Brands:** 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		

	Prescription Drug Benefits		
	In-Network Only Plan	**Choice Plan**	**High Deductible Plan with HSA[1]**
Copay/coinsurance — Mail Service program or Maintenance Choice program Copay/coinsurance for a 90-day supply through the CVS Caremark **Mail Service program or Maintenance Choice program (through a CVS pharmacy)** after you meet your deductible.			
Generic drug[2]	$20		
Preferred brand-name drug[3]	$75		
Non-preferred brand-name drug	50% of the cost of the drug, with a minimum payment of $125, to a maximum of $375		
Certain preventive care drugs as required by ACA	**Generics and Single Source Brands:** 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		
Copay/coinsurance — specialty medication Copay/coinsurance for a 31-day supply of **specialty medication dispensed through the CVS Specialty Pharmacy** after you meet your deductible.[4]			
Generic drug[2, 4]	$20		
Preferred brand-name drug[3, 4]	25% of the cost of the drug, with a minimum payment of $50, to a maximum of $150		
Non-preferred brand-name drug4	50% of the cost of the drug, with a minimum payment of $100, to a maximum of $250		
Out-of-network benefits Benefits at an **out-of-network pharmacy**.			
	Reimbursed at the contracted rate after you have met the annual deductible and paid the applicable copay		
Lifetime maximum benefit for fertility drugs			
	Fertility drugs are limited to $7,500 per lifetime per covered person		

1 In the High Deductible Plan with HSA, you must meet your combined medical/prescription drug deductible before the Program will pay benefits, except for certain preventive drugs. If you are enrolled in the High Deductible Plan with HSA, you are not eligible to participate in the PrudentRX Copay program. To determine whether your medication is considered preventive, visit **www.caremark.com**. Your cost for these preventive drugs is the applicable copay or coinsurance, which will count toward your out-of-pocket maximum.

2 The use of generic equivalents whenever possible (through both the retail and CVS Caremark Mail Service programs) is more cost-effective. Ask your medical professional about this distinction. If you or your doctor requests 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 copay for the generic drug Pharmacy and/or CVS Caremark Mail Service Dispense as Written (DAW) penalty amounts do not count toward your pharmacy or medical plan's annual deductible or out-of-pocket maximum.

3 Citi does not determine preferred brand-name drugs. Rather, CVS Caremark brings together an independent group of practicing physicians and pharmacists who meet quarterly to review the preferred brand-name formulary list and make determinations based on current clinical information. Call CVS Caremark **Customer Care at 1 (844) 214-6601** or visit **www.caremark.com** for a copy of its Preferred Formulary (updated at least quarterly).

4 You are required to fill the prescription through CVS Specialty Pharmacy. However, specialty prescriptions can be dropped off or picked up at a CVS retail pharmacy (yet, they typically take more time to fill than non-specialty prescriptions). In the event of an emergency, please contact CVS Specialty Pharmacy Services to fill the prescription. You will be charged only the applicable retail/specialty copay.

Note: For the In-Network Only Plan and Choice Plan, pharmacy and/or CVS Caremark Mail Service copays do not count toward your medical plan's annual deductible or out-of-pocket maximum, as there is a separate pharmacy deductible and a separate pharmacy out-of-pocket maximum. See "Choice Plan and In-Network Only Plan – PrudentRx Copay Program" on page 167 for In-Network Only Plan and Choice Plan details.

Meeting Your Deductible

When you buy a prescription drug, you must meet the applicable deductible (individual or family) before the Program will pay benefits. Keep in mind, however, that you will only be required to pay the negotiated price at network pharmacies regardless of whether you have met your deductible.

For answers to your questions about the applicable deductibles, call CVS Caremark Customer Care at **1 (844) 214-6601.**

Your Out-of-Pocket Maximum

There is a separate prescription drug out-of-pocket maximum ($1,500 per individual and $3,000 per family) under the In-Network Only Plan and Choice Plan. This feature is designed to help protect you from a large annual expense for prescription drugs, since this is the most you will ever pay for prescriptions per year. Once you reach the out-of-pocket maximum, the Program will pay 100% of your covered prescription costs for the remainder of the plan year.

Keep in mind, you will still pay 100% of the prescription cost after the out-of-pocket maximum is met after the third fill of a covered maintenance medication through a non-CVS pharmacy.

There is a combined medical and prescription drug out-of-pocket maximum under the High Deductible Plan with HSA of $5,000 individual and $10,000 ($6,850 per individual) family in-network ($7,500 individual and $15,000 family out-of-network). This amount includes your medical/prescription drug deductible, coinsurance and copays. This represents the most you will have to pay out of your own pocket in a plan year.

Note: For in-network services under the High Deductible Plan with HSA, the family out-of-pocket maximum is $10,000, but 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 entire family's in-network health care expenses for the rest of the year.

For answers to your questions about the out-of-pocket maximum, call CVS Caremark Customer Care at **1 (844) 214-6601**.

Retail Network Pharmacies with CVS Caremark

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 (including those within a Target) that participate in the CVS Caremark network and obtain up to a 31-day supply for your copay (once you meet your deductible).

For some drugs to be covered, your doctor may need to provide additional documentation. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

To find out whether a pharmacy participates in the CVS Caremark network:

- Ask your pharmacist;
- Visit **www.caremark.com** to access the pharmacy locator;
- Download the CVS Caremark free mobile app from your device's app store (search for "CVS Caremark"); or
- Call CVS Caremark Customer Care at **1 (844) 214-6601.**

A network pharmacy will accept your prescription and prescription drug ID card and, once you have met your deductible, will charge you the appropriate copay/coinsurance for a covered drug. Your copay/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the CVS Caremark Preferred Formulary, or a non-preferred drug. If you purchase a drug that is not covered under the Program, you will pay 100% of the full, non-discounted price of the drug. See "Drugs Not Covered" on page 173 for more information.

Using Your Prescription Drug ID Card

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

Upon your enrollment, CVS Caremark will receive your eligibility information. If you do not have an ID card, please ask your pharmacist to contact CVS Caremark so they can attempt to process the prescription through your pharmacy insurance. You can print out a temporary ID card online at **www.caremark.com** You can also download the CVS Caremark mobile app to access your virtual ID card.

If you do not use your ID card at network pharmacies, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed. You will be reimbursed according to the CVS Caremark contracted rate for the covered prescription drug after you have met the annual deductible and paid the applicable copay. Submissions for reimbursement can be processed by utilizing the Caremark web portal (**Caremark.com**), the Caremark mobile app (available for Android and Apple), or through a claim form. To obtain a claim form, visit "Forms and Documents" on **citibenefits.com**.

Send all completed claim forms to:

CVS Caremark Pharmacy
P.O. Box 52136
Phoenix, Arizona 85072-2136

CVS Caremark Mail Service

Through CVS Caremark Mail Service, you can purchase up to a 90-day supply of medication at one time and have it shipped directly to your home. You will make one home-delivery copay for each prescription drug or refill after you first meet your deductible, and save money.

When you use CVS Caremark Mail Service:

- Your medications are dispensed by one of the CVS Caremark Mail Service pharmacies and delivered to your home.
- Medications are shipped by standard delivery (7 – 10 business days, including shipping time) at no cost to you. You can also request express shipping for an additional cost. (Next day or second day express shipping options are available.). Please note that processing requires 1-2 business days for refills; 4 – 5 business days for new prescriptions in addition to express shipping time.
- You can order and track your refills online at **www.caremark.com or via the CVS Caremark mobile app**. You can also call CVS Caremark at **1 (844) 214-6601** to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.

The Convenience of Mail Service

Receive up to a 90-day supply of maintenance medications delivered to your home, and save money by enrolling in your prescription drug plan's mail Service program. To enroll in CVS Caremark Mail Service, visit **www.caremark.com**, or call **1 (844) 214-6601.**

If you are a first time Mail Service user, you can get started by using the Fast Start program. You can dial **1 (844) 214-6601** and speak to a CVS Caremark representative who will gather important information and contact your physician to obtain a 90-day prescription on your behalf.

Please note that CVS Caremark does not accept manufacturer coupons for prescriptions filled through the Mail Service pharmacy.

CVS Caremark Maintenance Choice® Program

Maintenance Choice is a program available to you that provides added convenience in filling your maintenance drugs. You may obtain a 90-day prescription at a CVS pharmacy. Keep in mind that the prescription must be written to dispense in a 90-day supply, plus any appropriate refills.

When you purchase prescriptions through the CVS Caremark Maintenance Choice® Program, you pay the appropriate deductible and/or coinsurance and receive up to a 90-day supply of your medication.

Choose one of four ways to start filling your 90-day prescriptions through CVS Caremark:

1. **At a CVS location** -- Take your prescription to a CVS/pharmacy location
2. **By phone** -- Call CVS Caremark Customer Care at **1 (844) 214-6601**
3. **By mail** -- Fill out and return a Mail Service order form. You can download one from the CVS Caremark website, **www.caremark.com**, or request one from CVS Caremark Customer Care
4. **Online:** Visit **www.caremark.com** and log in. You may then request a new Mail Service prescription from your doctor using "Request a Prescription with Fast Start."

If you are currently receiving prescription medications through a program other than CVS Caremark Maintenance Choice® or the CVS Mail Service Pharmacy, ask your doctor to write a new prescription (for up to a 90-day supply plus refills).

Specialty Medication with CVS Caremark

The CVS Caremark 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. You are required to fill the prescription through CVS Specialty Pharmacy. However, specialty prescriptions can be dropped off or picked up at a CVS retail pharmacy (they typically take more time to fill than non-specialty prescriptions). In the event of an emergency, please contact CVS Specialty Pharmacy Services to fill the prescription. Prescriptions sent to CVS Caremark Mail Service that should be filled by the Specialty Pharmacy will be forwarded. Specialty medications purchased through the CVS Specialty Pharmacy are limited to a 31-day supply or less. It's important to know that prescriptions for specialty medications take longer to fill than traditional medications due to added steps and approvals.

The CVS Specialty Pharmacy offers the following:

- Once you are using the program, the CVS Specialty Pharmacy 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, or to a CVS pharmacy of your choice, within 48 hours of ordering.
- You are not charged for needles, syringes, bandages or any supplies needed for your injection program.
- A team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- The CVS Specialty Pharmacy will send monthly refill reminders to you.

To learn more about CVS Caremark's Specialty Pharmacy services, including the cost of your prescription drugs, call **1 (844) 214-6601**.

CVS Caremark AccordantCare Health Services

The AccordantCare program is designed to help members find the answers and support they need to manage their health care needs and maximize their overall health status. This program is a voluntary, no-cost service that offers covered employees and dependents with one of eight complex and chronic conditions who fill their specialty medications through CVS Specialty with the opportunity to work with CVS Caremark AccordantCare Health Management Nurses.

AccordantCare registered nurse care managers serve as liaisons and advocates, facilitating relationships between members, physicians, specialists, insurance companies and employers to ensure high-quality care delivery within realistic cost-containment strategies. AccordantCare nurses can help identify gaps in care, improve patient experience and outcomes, reduce costs, and avoid disease complications and hospitalizations. Care managers continually evaluate and coordinate treatment progress to make sure that members receive the most appropriate care for their individual needs. Covered conditions are:

- Crohn's disease;
- Cystic fibrosis;
- Gaucher disease;
- Hemophilia;
- Hereditary angioedema (HAE)
- Multiple sclerosis;
- Rheumatoid arthritis;

- Systemic lupus erythematosus; and
- Ulcerative colitis.

Specialty Medication Copayment Assistance

High Deductible Plan with HSA

Specialty medications may qualify for third-party copayment assistance programs that could lower your out of-pocket costs for those products. In many of these programs, your copay/coinsurance may be reduced for a 31-day supply of your specialty medication. Please note that any assistance received will not count towards your annual deductible or total out-of-pocket maximum you are required to pay related to Plan coverage.

CVS Specialty® will help you receive third-party copayment assistance for these particular prescribed drugs. Enrollment in the program is voluntary. If you choose not to participate in the copayment assistance programs, you will be required to pay the full prescription drug copay/coinsurance amount, which will count towards your annual deductible or total out-of-pocket cost where applicable.

Eligibility for third-party copay assistance programs is dependent on the applicable terms and conditions of a particular program. The terms and conditions of such programs are subject to change. This program is offered as part of your Plan's exclusive specialty pharmacy network with CVS Specialty. Please note that the specialty drugs eligible for specialty copayment assistance programs is subject to change.

To enroll, call CVS Caremark Customer Care at 1 (844) 214-6601. The CVS Specialty Care Team will coordinate the filling of your specialty medication prescription and enroll you in the available manufacturer's copay assistance program. Once enrolled in the program, your medication will continue to be filled through CVS Specialty Pharmacy, your specialty mail service provider.

Additionally, the designated pharmacy will enter the copay assistance details when submitting the initial and subsequent claims and the copay assistance benefit will be applied by CVS Specialty to all related prescriptions.

You may continue to use copay cards to help reduce your copay/coinsurance. However, any resultant reduction in your copay/coinsurance amount from the use of the card will not apply towards your annual deductible or out-of-pocket maximum that you are required to pay related to plan coverage.

Choice Plan and In-Network Only Plan – PrudentRx Copay Program

If you are enrolled in the Choice Plan or the In-Network Only Plan, you and your family will be eligible to participate in the PrudentRx Copay Program for certain specialty medications from drug manufacturers. PrudentRx reduces your cost share for eligible medications thereby reducing your out-of-pocket expenses. The PrudentRx Copay Program assists members by helping them enroll in manufacturer's copay assistance programs.

If you are not enrolled in the PrudentRx program, medications in the specialty tier will be subject to a 30% coinsurance on specialty medications that are eligible for the Prudent Rx program, and the amount may not count towards the deductible or out-of-pocket maximum. However, enrolled members who get a copay card for their specialty medication (if applicable) will have a $0 out-of-pocket coinsurance for their prescriptions covered under the PrudentRx Copay Program.

If you currently take one or more medications included in the PrudentRx Program Drug List available at https://www.prudentrx.com/prudentexh (this list is subject to change), you will receive a welcome letter and phone call from PrudentRx that provides specific information about the program as it pertains to your medication, including how to enroll. If you take one or more eligible specialty medications, you must speak with a representative from PrudentRx to register for the specialty medication copay assistance program.

If you or a covered family member are not currently taking, but will start a new medication covered under the PrudentRx Copay Program, you can reach out to PrudentRx directly or they will contact you the day after your applicable prescription is filled, so you can take full advantage of the PrudentRx program. PrudentRx

can be reached at **1 (800) 578-4403** to address any questions regarding the PrudentRx Copay Program. The CVS Specialty pharmacy may also transfer you to PrudentRx when filling your prescription.

The amount that a participant is required to pay for certain specialty medications that are not subject to special treatment under the Affordable Care Act (not determined to be "essential health benefits" related to prescription drugs) will not count towards the Plan's out-of-pocket maximum, regardless of the payment source (the participant or the manufacturer copayment assistance program). A list of specialty medications that are not considered to be "essential health benefits" is available at https://www.prudentrx.com/prudentexh.

For questions about the PrudentRx Copay Program, please call **1 (800) 578-4403**.

CVS Health Pharmacy Advisor Counseling Program

This program helps individuals with chronic conditions improve their medication adherence and close gaps in care. You may consult a CVS pharmacist at a time that's convenient for you for quick, confidential advice, information about medications and their effects on your body and guidance to help you stay on track with your medications.

Dispense as Written (DAW) Solutions

The Dispense as Written Solutions program is 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 or your doctor chooses the brand-name drug when a generic exists, you must pay the difference in cost between the brand-name drug and the generic drug (the "penalty") in addition to your copay. This charge will be applied regardless of whether the doctor or you require the brand-name drug to be dispensed.

Note that pharmacy and/or CVS Caremark Mail Service Dispense as Written (DAW) penalty amounts do not count toward your pharmacy or medical plan's annual deductible or out-of-pocket maximum.

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 whether your prescription qualifies for step therapy or is subject to limitations, call CVS Caremark at **1 (844) 214-6601**. Participation in this program is optional.

If you have a discontinuance or lapse in therapy (typically 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 whether the cost of the brand-name medication will be covered under the Program. 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 Mail Service.
2. The pharmacist enters the prescription information into the CVS Caremark information system.
3. The claim is submitted for processing — the CVS Caremark system automatically looks back at the member’s claim history to see if the member had a prescription filled in that time period (typically 130 days) for the alternative drug.
4. If a claim for an alternative, lower cost 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 or 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 regarding whether the request has been approved or denied.

Call CVS Caremark at **1 (844) 214-6601** or **www.caremark.com** to obtain information about whether your medication requires step therapy and/or about the applicable copay for the generic, preferred brand or non-preferred category of drug.

Compound Medications

For compound drugs to be covered under the Program, they must satisfy certain requirements. In addition to being medically necessary and not experimental or investigative, compound drugs must not contain an ingredient on a list of excluded ingredients. Furthermore, the cost of the compound must be determined by CVS Caremark to be reasonable (e.g., if the cost of any ingredient has increased more than 5% every other week or more than 10% annually, the cost will not be considered reasonable). Any denial of coverage for a compound drug may be appealed in the same manner as any other drug claim denial under the Program.

Prior Authorization with CVS Caremark

For you to purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive prior authorization from CVS Caremark 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 whether your medication requires prior authorization or is subject to a quantity limit, call CVS Caremark at **1 (844) 214-6601** or visit the CVS Caremark website at **www.caremark.com**. Your pharmacist can also determine whether 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 (844) 214-6601**. After your physician provides the required information, CVS Caremark will review your case, which typically takes one to two business days. Once the review is completed, CVS Caremark 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 its full cost to you.

Medication Review with CVS Caremark

Under certain circumstances, you and your physician may request that CVS Caremark perform a medical review of your medications. For additional information and instructions on how your physician can request a review, call CVS Caremark at **1 (844) 214-6601**.

Transform Diabetes Care® Program

If you or a covered dependent are enrolled in a Citi medical plan, have diabetes and meet the standard requirements, CVS Health may contact you to discuss your diabetes management and the Transform Diabetes Care® Program. The program offers three key components:

- A personalized blood glucose meter to meet your specific needs;
- 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.

Opioid Management Program

The Opioid Management Program limits the quantity of opioids and requires step therapy, and is designed to (i) help improve management of opioid use; and (ii) reduce potential misuse/abuse. It is aligned with the Guideline for Prescribing Opioids for Chronic Pain issued by the Centers for Disease Control and Prevention (CDC). The Program uses the CDC criteria of Morphine Milligram Equivalent (MME) to limit the quantity of opioid products. Prior authorization requests can be made if your doctor believes the dose should exceed the MME within the CDC recommendation. The Opioid Management Program is not intended to be applicable to cancer treatment or palliative end-of-life care.

High Deductible Plan with HSA Information

The High Deductible Plan with HSA covers the cost of certain preventive drugs without having to meet a deductible. You will pay the applicable copay or coinsurance, which will count toward your combined medical/prescription drug out-of-pocket maximum.

For a list of these preventive medications, call CVS Caremark at **1 (844) 214-6601**. You can also visit **www.caremark.com**.

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;
- Compound medications of which at least one ingredient is a legend drug not included on the compound exclusion list;
- Insulin;
- Needles and syringes;
- Over-the-counter (OTC) diabetic supplies (except blood glucose testing monitors);
- Oral and injectable contraceptives;

- Fertility agents (for members covered under the Citi medical and prescription drug plan only; no coverage is provided for a donor who is not covered under the Plan);
- Certain drugs used for hormone therapy such as testosterone, progesterone, and GnRH agonists (for FTtM) and estrogen, antiandrogens, and GnRH agonist (for MtF);
- Legend vitamins;
- Amphetamines used for ADHD, through age 18;
- Drugs to treat impotency, for males (quantity limits apply);
- Retin-A/Avita (cream only), through age 34; and
- Retin-A (gel), through age 34.

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

- Legend anti-obesity preparations;
- Amphetamines used for ADHD, 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 the Affordable Care Act, certain prescribed drugs, as indicated below, are covered at 100%, not subject to the deductible, if certain conditions are met. Certain dosage and other restrictions apply. If conditions are not met and generic drugs are subject to the applicable copay or deductible.

	Criteria
Aspirin (to prevent cardiovascular disease)	> Generic OTC with prescription > Adults (age 50 – 59)
Aspirin (for preeclampsia)	> Generic OTC with prescription > 81 mg > Females age 12 to 59
Bowel preps	> Generic and Single source brands prescription drugs > Adults (age 45 to 74)
Contraceptive methods for women	> Generic and single source brands barrier methods (diaphragm and cervical cap) > Generic and single source brands hormonal contraceptives > Generic and single source brands emergency contraceptives > Prescribed OTC generic contraceptives (except condoms or other men's contraceptives)
Fluoride (oral formulations)	> Brand and generic prescription drugs > Children 6 months of age through 5 years of age
Folic acid	> Generic OTC (with prescription) and generic prescription drugs > Women through age 55
Smoking cessation	> OTC (with prescription) and prescription drugs > Adults age 18 and over
Vitamin D	> Generic OTC (with prescription) and generic prescription drugs > Adults age 65 and over

Health Care Reform In compliance with the Affordable Care Act, certain prescribed drugs, as indicated below, are covered at 100%, not subject to the deductible, if certain conditions are met. Certain dosage and other restrictions apply. If conditions are not met and generic drugs are subject to the applicable copy or deductible.	
	Criteria
Tamoxifen and Raloxifene for breast cancer prevention	> Generic prescription drugs > Women ages 35 and over for primary prevention only (physician or member must request no copay)
Preexposure Prophylaxis	> Truvada 200mg-300mg with prescription > Preventative use only > Quantity limit (1 tab/day) > Brand until generic becomes available
Statins	> Generic low-to-moderate-dose statins for members ages 40 to 75

Other Limits

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

- Fertility medications (subject to a lifetime maximum benefit limit of $7,500 per covered person);
- Erectile dysfunction medications;
- Anti-influenza medications;
- Smoking deterrents;
- Migraine medications;
- H2-receptor antagonists; and
- Proton pump inhibitors.

Drugs Not Covered

For a list of the drugs and products that are not covered under the Citigroup Prescription Drug Program, as well as a list of covered alternatives for select medications, see the 2022 CVS Caremark Preferred Drug List Exclusions at Citi Benefits Online. You 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.

If you have any questions about coverage for a specific drug, please call CVS Caremark Customer Care at **1 (844) 214-6601**.

General exclusions include: 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 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, continuous blood glucose monitors, and implanted and external insulin delivery pump devices and supplies (covered under medical benefits);
- 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®);
- Deuxis and Vimovo;
- Injectable 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 CVS Caremark

The amount of time CVS Caremark 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[1]

Type of Claim	Timeline after Claim Is Filed
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[1]
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

[1] 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 Treasury (the Agencies) issued 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 COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, 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 (Agencies' deadline).

If your deadline to file a claim or appeal falls within the National Emergency, you will have up until the Agencies' deadline to submit your claim or appeal.

For more information, contact the Claims Administrators as detailed under "Claims Administrators" in the *Administrative Information* section, or call the Citi Benefits Center via ConnectOne at **1 (800) 881-3938** for additional help. From the Benefits menu, select the appropriate option. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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 Program's appeals procedure.

CVS Caremark First-Level Appeal

If you disagree with a claim determination after following the steps outlined in "CVS Caremark Urgent Claim Appeals" on page 176, 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.

CVS Caremark 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 Program. The Claims Administrator's decisions are conclusive and binding.

You will receive written or electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

- The specific reason or reasons for the denial of the appeal;
- Reference to the specific Plan provisions on which the benefit determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- A statement describing any voluntary appeal procedures offered by the Plan and a statement of your right to bring an action under Section 502(a) of ERISA;

- If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge on request; and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Legal Action

No suit or action for benefits under the Plan shall be sustainable in any court of law or equity, unless you complete the appeals procedure, and unless your suit or action is commenced within 12 consecutive months after the committee's final decision on appeal, or if earlier, within two years from the date on which the claimant was aware, or should have been aware, of the claim at issue in the proceeding. The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary.

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:

CVS Caremark Appeal Program
P.O. Box 52136
Phoenix, Arizona 85072-2136

Telephone: **1 (800) 294-5979**
Fax: **1 (888) 836-0730**