Vision

The Aetna Vision Plan, offers a variety of routine vision care services and supplies.

You may enroll in the Plan as a new hire or during annual enrollment. You can change your election if you have a qualified status change, as described in the *Eligibility and Participation* section.

When you enroll in the Plan, you will receive two ID cards in the mail.

The Aetna Vision Plan offers both network and out-of-network benefits. For example, you can obtain an annual eye exam from a network provider while purchasing frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

The Aetna Vision Plan is underwritten by Aetna Life Insurance Company. Certain claims administration services are provided by First American Administrators, Inc., and certain network administration services are provided through EyeMed Vision Care, LLC.

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Benefits at a glance

The following table summarizes the vision benefits available to you and your eligible dependents:

Network benefit	Coverage
Routine eye exam	• Covered at 100% including dilation, one exam per calendar year
Frames and lenses	• One pair of frames and lenses per calendar year • Frames covered at 100% up to the frame allowance below • Lenses covered at 100% • $150 frame allowance; member pays 80% of balance over the $150 plan allowance • 40% discount on additional pairs of glasses
Contact lenses (in lieu of glasses)	• Covered at 100% up to the contact lense allowance below; one allowance per calendar year in lieu of eyeglasses • $130 allowance for conventional or disposable contact lenses; member pays 85% of balance over $130 allowance for conventional contact lenses and 100% over $130 allowance for disposable contact lenses • 15% discount on additional conventional contact lens purchases • Medically necessary contact lenses covered in full
Laser vision correction (Lasik)	• 15% off retail price or 5% off promotional price; must use the U.S. Laser Network to receive discount
Maximum benefit	• The most the Plan will pay for the service or benefit; excludes copayments and allowances
Out-of-network benefit	**Coverage**
Routine eye exam	• Up to $50
Frames/lenses	• Frame; up to $100 • Single vision lenses up to $50, bifocal up to $60, trifocal up to $90, and lenticular up to $125
Contact lenses	• Contact lenses; up to $130 • Medically necessary contact lenses; up to $225

Network services

To receive the greatest value for your dollar, you should receive vision care services from an Aetna Vision network provider. However, you can use out-of-network providers and receive a benefit.

Network providers are licensed doctors in your area who have contracted to provide vision care services at a discount. You and your covered family members can select a different Aetna Vision network provider each time you receive vision care services.

Your doctor may apply to join the Aetna provider network by calling EyeMed at **1-800-521-3605**. Membership in the network is not guaranteed.

Using network providers

To find a network provider in your area and schedule an appointment, follow these instructions.

- **If you are a member:** Visit Aetna Navigator at **www.aetna.com** or visit **www.aetnavision.com**, and enter the employee's member ID number.
- **If you are not a member:** During your enrollment period visit **www.AetnaVisionOE.com/avp1**.
- You may also call the Aetna Vision Plan at **1-877-787-5354**. An automated voice response unit (available 24/7) or a Member Services representative (available from 7:30 a.m. to 11 p.m. ET on weekdays and Saturdays and 11 a.m. to 8 p.m. on Sundays) will assist you.

Once you have obtained the name of a network provider, call him or her to schedule an appointment and provide the Citi employee's member ID number. If you are calling for services for a covered dependent, you will need to provide your dependent's date of birth.

Note: Claim forms are not required when obtaining network services.

Network benefits

Network benefits include:

- Routine eye exam: One eye exam, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: One pair of eyeglasses each calendar year; frame allowance of $150 per calendar year; members pay 80% of the balance over this allowance;
- Contact lenses in lieu of eyeglasses: $130 allowance per calendar year and a 15% discount over the allowance for conventional contact lenses; and
- A 40% discount on additional pairs of glasses at most network providers.

The following lenses are covered at 100%: plastic lenses (single, bifocal, or trifocal); all prescription ranges, including post-cataract lenses; tinting of plastic lenses; standard and premium progressive addition multifocals; polycarbonate lenses; oversize lenses; ultraviolet coating; blended segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; intermediate-vision lenses; anti-reflective coatings; hi-index lenses; polarized lenses; and plastic photosensitive lenses.

Note: Some brand exceptions may apply and may require a copayment.

Mail-order contact lenses

You can purchase replacement or additional pairs of contact lenses by calling the Aetna Vision Plan at **1-877-787-5354** or visiting **www.aetnavision.com**.

Travel and student coverage

If you or a covered dependent(s) requires vision care services while traveling or away at school, call the Aetna Vision Plan at **1-877-787-5354**.

Out-of-network benefits

If you receive services outside the Aetna network, the Plan will provide reimbursements of up to the following amounts:

- Annual exam: $50;
- Lenses: Single vision, $50; bifocal, $60; trifocal, $90; lenticular, $125;
- Frame only: $100; and
- Contact lenses: $130 elective; $225 medically necessary.

When you receive services outside the provider network, you will need to submit your itemized paid receipts with a Vision Claim Submission Form. You can visit **www.aetnavision.com** to obtain the form.

Mail the completed form and your itemized paid receipts to:

Aetna Vision
Attn: OON Claims
P.O. Box 8504
Mason, OH 45040-7111

Allow at least 14 calendar days for your claims to be processed after receipt. A check and/or explanation of benefits will be mailed within seven calendar days of the date your claim is processed. If you have any questions about your claims, call the Aetna Vision Plan at **1-877-787-5354**.

Laser vision correction

Laser vision correction is not covered under the Plan. However, if you use a provider in the U.S. Laser Network, you are eligible for up to a 15% discount off the retail price or a 5% discount off any promotional price. The U.S. Laser Network comprises more than 550 provider locations, including Lasik*Plus* Vision Centers nationwide, and offers a broad choice of the latest technologies in the industry.

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call the Aetna Vision Plan at **1-877-787-5354** or visit **www.eyemedlasik.com**.

What is not covered

Below is a partial list of exclusions and limitations:

- Special vision procedures, such as orthoptics, vision therapy, or vision training;
- Vision services that are covered, in whole or in part, under any other part of this plan or under any other plan of group benefits provided by the policyholder, or under any Workers' Compensation law, or any other law of like purpose;
- An eye exam that is required by an employer as a condition of employment, or that an employer is required to provide under a labor agreement, or that is required by any law of a government;
- The cost of prescription sunglasses in excess of the amount that would be covered for non-tinted lenses;
- Replacement of lost, stolen, or broken prescription lenses or frames; and
- Any exams given during your stay in a hospital or other facility for medical care.

Other exclusions and limitations may apply.

Claims and appeals for the Aetna Vision Plan

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	• Decision within 30 days; one 15-day extension (notice of the need for an extension must be given within 30 days) • 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 care or treatment requiring approval before the care or treatment is received)	• 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 15 days • You have 45 days to submit any additional information needed to process the claim.

Complaints

If you are dissatisfied with the service you receive from the Plan or want to complain about a provider, you may write to Aetna Customer Service within 30 calendar days of the incident. You must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter.

Aetna will review the information and provide a written response within 30 calendar days of the receipt of the complaint, unless additional information is needed and the information cannot be obtained within this period. The notice of the decision will tell you what to do to seek an additional review.

Appeals of adverse benefit determinations

If Aetna notifies you of an adverse benefit determination — that is, a denial, reduction, termination of, or failure to provide or make payment (in whole or in part) for a service, supply or benefit — you may submit an appeal.

An adverse benefit determination may be based on:

- Your eligibility for coverage;
- The results of any Utilization Review activities;
- A determination that the service or supply is experimental or investigational;
- A determination that the service or supply is not medically necessary; or
- Contractual issues.

The Plan provides two levels of appeal. It will also provide an option to request an external review of the adverse benefit determination.

You have 180 calendar days following the receipt of notice of an adverse benefit determination to request your level-one appeal. Your appeal may be submitted in writing and should include:

- Your name;
- Your employer's name;
- A copy of Aetna's notice of an adverse benefit determination;
- Your reasons for making the appeal; and
- Any other information you would like to have considered.

You may file your appeal in writing or by telephone:

- In writing: Send your appeal to Customer Service at the address on your Aetna Vision Plan ID card, or
- By telephone: Call the Aetna Vision Plan at **1-877-787-5354**.

You may also choose to have another person (an authorized representative) make the appeal on your behalf by providing written consent to Aetna.

Level-one appeal

A level-one appeal of an adverse benefit determination shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

For preservice claims (may include concurrent care claim reduction or termination), Aetna shall issue a decision within 15 calendar days of receipt of the request for an appeal.

For post-service claims, Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Level-two appeal

If Aetna upholds an adverse benefit determination at the first level of appeal, you or your authorized representative has the right to file a level-two appeal. The appeal must be submitted within 60 calendar days following the receipt of notice of a level-one appeal.

A level-two appeal of an adverse benefit determination of an urgent care claim, a pre-service claim, or a post-service claim shall be made by Aetna personnel who were not involved in making the adverse benefit determination.

For preservice claims (may include concurrent care claim reduction or termination), Aetna shall issue a decision within 15 calendar days of receipt of the request for a level-two appeal.

For post-service claims, Aetna shall issue a decision within 30 calendar days of receipt of the request for a level-two appeal.

Exhaustion of process

You must exhaust the applicable level-one and level-two processes of the Aetna appeal procedure before you do any of the following regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter within the scope of the appeals procedure:

- Contact your state's Department of Insurance to request an investigation of a complaint or appeal; or
- File a complaint or appeal with your state's Department of Insurance; or
- Establish any litigation, arbitration, or administrative hearing.

External review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of Aetna's denial of a claim; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

Aetna's claim denial letter will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim-denial letter. You must also include a copy of the final claim-denial letter and all other pertinent information that supports your request.

Aetna will contact the Independent Review Organization that will conduct the review of your claim. The Independent Review Organization will select a physician reviewer with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits.

You will be notified of the decision of the Independent Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the requested service or supply would endanger your health. Expedited reviews are decided within three to five calendar days after Aetna receives the request.

Aetna will abide by the decision of the independent reviewer, except where Aetna can show conflict of interest, bias, or fraud.

You are responsible for the cost of compiling and sending to Aetna the information that you wish to be reviewed by the Independent Review Organization. Aetna is responsible for the cost of sending this information to the Independent Review Organization and for the cost of the external review.

For more information about Aetna's External Review program, call the Aetna Vision Plan at **1-877-787-5354**.