Vision

The Citigroup Vision Benefit Plan (the "Vision Plan") offers a variety of routine vision care services and supplies.

When you can enroll in and/or make changes to Vision Coverage

You may enroll in the Vision Plan as a new hire or during Annual Enrollment. Your election is generally in effect from your eligibility date through the end of the calendar year. You can change your election during the year if you have a qualified change in status, as described in the *Eligibility and Participation* section.

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

The Vision Plan offers both in-network and out-of-network benefits. For example, you can obtain an annual eye exam from an in-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 by contacting Aetna Vision.

The Vision Plan is fully insured and 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.

For more information on the vision coverage available, see the Aetna Vision Plan fact sheet.

Save Money with Spending Accounts

Take advantage of the *Health Care Spending Account* or *Limited Purpose Health Care Spending Account* to pay for eligible medical, dental and vision expenses with before-tax dollars. For more information, visit the spending account website through My Total Compensation and Benefits. From the main page, click on "TRIP and Spending Accounts."

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Benefits At a Glance

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

In-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 > Standard plastic lenses (single vision, bifocal, trifocal and lenticular) covered at 100% once every calendar year > Standard progressive lenses covered at 100% > Premium progressive lenses covered at 100% after copay: – Tier 1: $20 copay, – Tier 2: $30 copay, – Tier 3: $45 copay. – Tier 4: $120 plan allowance and you will pay the balance > Lens enhancements covered at 100% including: UV treatment, tint (solid and gradient), standard plastic scratch coating, standard polycarbonate, standard anti-reflective coating, photogrey glass, oversize lenses, intermediate vision lenses, blended bifocals, and polarized > Lens enhancements covered at 100% after a $30 copay: Hi-index lenses, photocromatic / transitions plastic > Frame allowance: The Plan pays $150 towards any frame available at the provider location once every 12 months; additional 20% off any balance over the $150 plan allowance > Up to a 40% discount on additional pairs of glasses
Contact lenses (in lieu of glasses)	> Covered at 100% up to the contact lens allowance below; one allowance per calendar year in lieu of eyeglasses > The Plan pays $130 towards elective conventional or disposable contact lenses; receive an additional 15% discount off any balance over $130 allowance for conventional contact lenses > Fit and follow up: Pay no more than $40 for standard contact lens fitting and receive a 10% discount off the retail price for premium contact lenses > 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
Out-of-Network Benefit	**Coverage**
Routine eye exam	> Up to $50 once every calendar year
Frames/lenses	> Frames: up to $100 > Single-vision lenses up to $50, bifocals up to $60, trifocals up to $90 and lenticular up to $125 > Progressive lenses: up to $90
Contact lenses	> Elective contact lenses: up to $130 > Medically necessary contact lenses: up to $225 > Fit and follow-up not covered

In-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 an out-of-network provider and still receive a benefit.

In-network providers are licensed physicians 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 physician may apply to join the Aetna provider network by calling EyeMed at **1 (800) 521-3605.** Membership in the network is not guaranteed.

Using In-Network Providers

To find an in-network provider in your area and schedule an appointment, follow these instructions:

> Visit Aetna Navigator at **www.aetna.com** or visit **www.aetnavision.com** and select "Find a Provider." You may also call the 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, Monday through Saturday, and 11 a.m. to 8 p.m. on Sunday) will assist you.

Once you have obtained the name of a provider in the Aetna network, call him or her to schedule an appointment and provide the Citi 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 services from in-network providers. However, you must submit a claim if you are receiving services out of network. Visit "Out-of-Network Benefits" on page 203 for more information on submitting a claim.

Online Providers

The Vision Plan includes in-network, on-line providers for your convenience. Register at **www .contactsdirect.com**, **www.glasses.com, www.ray-ban.com**, **www.targetoptical.com** or **www .lenscrafters.com** and shop for your favorite glasses or contacts. Your benefits will be applied during check out and your purchase shipped directly to the location you choose. Visit **www.aetnavision.com** and look for the "special offers" page to find discounts on shipping and other promo codes before shopping.

In-Network Benefits

In-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 20% of the balance over this allowance;

> Progressive lenses: $0 copay for standard, $20 copay for premium Tier 1, $30 copay for premium Tier 2, $45 copay for premium Tier 3 and $120 Plan allowance for premium Tier 4;

> Anti-reflective coating: $0 copay for standard, $15 copay for premium Tier 1, $30 copay for premium Tier 2 and $110 copay for premium Tier 3;

- Hi-index lenses: $30 copay;
- Contact lenses in lieu of eyeglasses: $130 allowance per calendar year and a 15% discount over the allowance for conventional contact lenses; and
- Up to a 40% discount on additional pairs of glasses at most network providers.

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

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

Mail-Order Contact Lenses

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

Travel and Student Coverage

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

Out-of-Network Benefits

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

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

When you receive services from out-of-network providers, you will need to submit your itemized paid receipts with a **Vision Claim Form**. You can visit Citi Benefits Online at **www.citibenefits.com** or Aetna at **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 claim, call the Vision Plan at **1 (877) 787-5354.**

Laser Vision Correction

You will receive a discount of 15% off retail or 5% off promotional prices for laser vision correction services. In addition, featured LasikPlus providers offer special member prices from $695 to $1,895 per eye plus a free LASIK exam. The LASIK discount is only available from U.S. Laser Network by calling **1 (800) 422-6600**.

What Is Not Covered

Below is a partial list of exclusions and limitations. For additional details about exclusions and limitations, call the Vision Plan at **1 (877) 787-5354** or visit **www.aetnavision.com.**

- Special vision procedures, such as orthoptics, vision therapy or vision training;
- Retinal imaging is excluded, but discounts may apply;
- Vision services that are covered in whole or in part under any other part of this plan, 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, 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 another facility for medical care.

Other exclusions and limitations may apply.

Complaints

If you are dissatisfied with the service you receive from the Vision Plan or want to complain about a provider, you may write to Aetna Customer Service within 30 calendar days of the incident.

Aetna Inc.
151 Farmington Ave.
Hartford, CT 06156

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 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.

Claims and Appeals

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 your vision plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Aetna will make an appeal decision within 30 days with one 15-day extension available if notice of the need for an extension is given within 30 days. Aetna must also give notice that more information is needed within 30 days after the claim is filed. You will then have 45 days to submit any additional information needed to process the claim.

See "Out-of-Network Benefits" on page 203 for more information on submitting a claim.

Appeals Process

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 Vision 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 receipt of notice of an Adverse Benefit Determination to request your first-level 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.

First-Level Appeal

A first-level appeal of an Adverse Benefit Determination shall be made by Aetna personnel who were not involved in making the Adverse Benefit Determination.

Aetna shall issue a decision within 30 calendar days of receipt of the request for an appeal.

Second-Level 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 second-level appeal. The appeal must be submitted within 60 calendar days following receipt of notice of a first-level appeal.

A second-level appeal of an Adverse Benefit Determination of an urgent care claim, a preservice claim or a post-service claim shall be made by Aetna personnel who were not involved in making the Adverse Benefit Determination.

Aetna shall issue a decision within 30 calendar days of receipt of the request for a second-level appeal.

Notice of Benefit Determination on Appeal

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 an 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 circumstances, or a statement that such explanation will be provided free of charge upon request.

Exhaustion of Process

You must exhaust the applicable first-level and second-level 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;
- 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, all the following requirements must be met:

- You have received notice of Aetna's denial of a claim;
- Your claim was denied because Aetna determined that the care was not medically necessary or was experimental or investigational;
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeals 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. If your deadline to file an external review of your denied claim falls within the defined COVID-19 Outbreak Period, you will have additional time to submit your claim, as the deadline will be recalculated to extend through the Outbreak Period, as noted earlier.

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 Vision Plan at **1 (877) 787-5354.**