Glossary

Definitions of certain terms used in the Citigroup Health and Insurance Benefits Handbook are included in this section.

Coinsurance: The portion of a covered expense that a participant pays after satisfying the deductible. For example, if a plan pays 80% of certain covered expenses, coinsurance for these expenses is 20%.

Covered expenses: Medical and related costs incurred by participants who qualify for reimbursement under the terms of the insurance contract.

Custodial care: Services and supplies furnished to a person mainly to help him or her in the activities of daily life (such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, and eating or preparing foods). These services include room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard:

- To whom they are prescribed;
- To whom they are recommended; or
- To who performs them.

Deductible: The amount of eligible expenses the participant and each covered dependent must pay each calendar year before a plan begins to pay benefits.

Goal amount: The total annual amount a participant elects to contribute on a before-tax basis to a Health Care Spending Account, Limited Purpose Health Care Spending Account or Dependent Day Care Spending Account. The annual contribution elected will be divided by the number of pay periods in the plan year and deducted from the employee's pay. For elections made during the plan year, the annual contribution amount will be divided by the number of remaining pay periods in the plan year and deducted from the employee's pay.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law designed to, among other things, ensure the portability of health insurance coverage and the ability to add family members to health coverage, as well as protect the privacy and security of health information.

Maximum allowed amount (MAA): Any charge that, for services rendered by or on behalf of an out-of-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule. This amount is determined by taking into account all pertinent factors, including:

- The complexity of the service;
- The range of services provided; and
- The geographic area where the provider is located.

How the MAA is calculated varies depending on which plan option you are enrolled in and which carrier you have. Contact your Plan for more details.

Medically necessary or medical necessity: Health care services and supplies that are determined by the Claims Administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;

- Consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health care coverage organizations or governmental agencies that are accepted by the Plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician;
- Must be provided by a physician, hospital or other covered provider under a plan;
- With regard to an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- Not be primarily scholastic, vocational, educational, developmental, experimental or investigational in nature; and
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed; or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, substance use disorder or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this document relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under a plan. No benefit will be paid for services that are not considered medically necessary, if applicable.

Network provider: A health care provider on a list of providers contracted with the Claims Administrator. Coinsurance or copays are discounted when plan members utilize network providers and facilities.

Non-occupational disease: A disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be deemed non-occupational regardless of the cause if proof is furnished that the person:

- Is covered under any type of Workers' Compensation law; and
- Is not covered for that disease under such law.

Non-occupational injury: An accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury that does.

Notification: A requirement that a participant calls his or her health plan option to coordinate any inpatient surgery and hospitalization and certain outpatient diagnostic/surgical procedures. Notification helps ensure that the participant obtains the most appropriate care for his or her condition in the most appropriate setting. Call your Plan for more information.

Out-of-pocket maximum: Total payments (includes copays, deductibles and coinsurance) toward eligible expenses that a covered person pays for him- or herself and/or dependents as defined by the applicable plans.

Once the maximum out-of-pocket amount has been met, a plan will pay 100% of maximum allowed amount (MAA) charges. For out-of-network services, when expenses incurred are higher than the MAA, the individual receiving the service is responsible for paying the difference between the provider's charge and the allowed amount, even if the out-of-pocket maximum has been reached.

Plan: The benefits (the "Citigroup Health and Insurance Plans" or collectively, the "Plans," and individually, a "Plan") described in this Benefits Handbook are:

- Citigroup Health Benefit Plan:
  - Aetna In-Network Only Plan;
  - Aetna Choice Plan;
  - Aetna High Deductible Plan with HSA);
  - Anthem BlueCross BlueShield In-Network Only Plan;
  - Anthem BlueCross BlueShield Choice Plan;
  - Anthem BlueCross BlueShield High Deductible Plan with HSA);
  - Fully insured health maintenance organizations (HMOs);
  - Citigroup Prescription Drug Program administered by CVS Caremark;
  - On-site medical clinics;
- Citigroup Dental Benefit Plan:
  - Cigna Dental HMO; and
  - MetLife Preferred Dentist Program (PDP);
- Citigroup Vision Benefit Plan;
- Citigroup Wellness Benefits;
- Citigroup Be Well Program;
- Citigroup Disability Plan;
- Spending accounts:
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP);
- Life insurance:
  - Basic Life insurance;
  - Basic Accidental Death and Dismemberment (AD&D) insurance;
  - Group Universal Life (GUL) insurance; and
  - Supplemental AD&D insurance;
- Citigroup Business Travel Accident/Medical (BTA/BTM) insurance; and
- Citigroup Legal Benefits Plan (MetLife Legal Plans).

Plan Administrator: The Plans Administration Committee of Citigroup Inc.

Plan year: January 1-December 31.

Precertification/prior authorization: A requirement that a participant calls his or her health plan option to coordinate any inpatient (i) surgery; (ii)hospitalization; (iii) mental health; or (iv) substance use disorder treatments and certain outpatient (i) diagnostic/surgical procedures; (ii) mental health; or (iii) substance use disorder treatments. Precertification determines medical necessity and helps ensure that the participant obtains the most appropriate care for his or her condition in the most appropriate setting. Call your plan for more information.

Obtaining a precertification means that the administrator has confirmed medical necessity of the service, but it does not guarantee coverage. Plan participants should contact Member Services to determine coverage.

No benefit will be paid for services that are not considered medically necessary.

Preventive care: Routine care exams based on:

- Guidelines from the American Medical Association and the United States Preventive Care Task Force;
- Guidelines from the Advisory Committee on Immunization Practices that have been adopted by the director of the Centers for Disease Control and Prevention;
- The Comprehensive Guidelines Supported by the Health Resources and Services Administration; and
- Physician recommendations.
- Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings and immunizations. See "Preventive Care" in the *Medical* section of the Citigroup Health and Insurance Benefits Handbook.

Provider: An individual or institution that provides preventive, curative, promotional or rehabilitative health care services in a systematic way to individuals, families or communities. An individual health care provider may include, but is not limited to, a health care professional, a physician assistant, a nurse practitioner, a chiropractor, an institution, a facility, a primary care center, a patient-centered medical home, a clinic, an ambulatory surgical center, an outpatient center, an urgent care center or a pharmacy.

Recognized charge: See "Maximum allowed amount (MAA)."

Wellness services: See "Preventive care."

Additional Medical Coverage Definitions

The following definitions apply to benefits provided under the Citigroup Health Benefit Plan (the "Plan"), unless clearly indicated otherwise.

Accredited school or college: An accredited secondary school, junior college, college or university, or a state or federally accredited trade or vocational school.

Ambulatory surgical center: A center, with a staff of doctors, that:

- Is licensed as required;
- Has permanent facilities and equipment to perform surgical procedures on an outpatient basis;
- Gives treatment by or under the supervision of doctors and nursing services when the patient is in the center;

- Does not have inpatient accommodations; and
- Is not, other than incidentally, used as an office or clinic for the private practice of a doctor or other professional provider.

Birth center: A specialized facility that is primarily a place for the delivery of children following a normal, uncomplicated pregnancy and that fully meets one of the following two tests:

- Is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Meets all the following requirements:
  - Is operated and equipped in accordance with any applicable state law;
  - Is equipped to perform routine diagnostic and laboratory exams, such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
  - Has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including, but not limited to, oxygen, positive pressure masks, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - Is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO) or registered nurse (RN);
  - Maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
  - Maintains an adequate medical record for each patient, with each record containing prenatal history, a prenatal exam, any laboratory or diagnostic tests, and a postpartum summary; and
  - Is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

A birth center that is part of a hospital, as defined herein, will be considered a birth center for the purposes of the Plan.

Brand-name drug: A drug that is under patent by its original innovator or marketer.

Calendar year: January 1 through December 31 of the same year. For new enrollees, the calendar year is the effective date of their enrollment through December 31 of the same year, unless otherwise provided in the Annual Enrollment materials.

Center of Excellence (COE): A health care facility that is identified as providing the most efficient and best quality of care.

Chiropractic care: Skeletal adjustments, manipulations or other treatments in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column. The following are not considered chiropractic care: chiropractic appliances, services related to the diagnosis and treatment of jaw joint problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders, or services for treatment of strictly non-neuromusculoskeletal disorders.

Claims Administrator: Aetna, Anthem BlueCross BlueShield, CVS Caremark and any other party designated as a claims fiduciary pursuant to a contractual relationship and as authorized by the Plans Administration Committee of Citigroup Inc. The Claims Administrator does not insure the benefits described in this document.

Comprehensive outpatient rehabilitation facility: A facility that is primarily engaged in providing diagnostic, therapeutic and restorative services to outpatients for the rehabilitation of injured or sick persons and that fully meets one of the following two tests:

- Is approved by Medicare as a comprehensive outpatient rehabilitation facility; or
- Meets all the following tests:
  - Provides at least the following comprehensive outpatient rehabilitation services:
    - Services of physicians who are available at the facility on a full- or part-time basis;
    - Physical therapy; and
    - Social or psychological services;
  - Has policies established by a group of professional personnel (associated with the facility), including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes and to provide for the carrying out of such policies by a full- or part-time physician;
  - Has a requirement that every patient be under the care of a physician; and
  - Is established and operates in accordance with the applicable licensing and other laws.

Controlled substance classes: Drugs and other substances that are considered controlled substances under the Controlled Substances Act are divided into five classes. An updated and complete list of the classes is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§ 1308.11 through 1308.15. Substances are placed in their respective classes based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential and the likelihood of causing dependence when abused. Some examples of the drugs in each class are listed below.

- **Class I controlled substances:** Substances in this class have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision and a high potential for abuse. Some examples of substances listed in Class I are heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone and 3,4-methylenedioxymethamphetamine ("Ecstasy").
- **Class II controlled substances:** Substances in this class have a high potential for abuse that may lead to severe psychological or physical dependence. Examples of Class II narcotics include hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), fentanyl (Sublimaze®, Duragesic®) and hydrocodone-containing products (Zohydro ER®, Vicodin®). Other Class II narcotics include morphine, opium and codeine.
- Examples of Class II stimulants include amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®) and methylphenidate (Ritalin®).
- Other Class II substances include amobarbital, glutethimide and pentobarbital.
- **Class III controlled substances:** Substances in this class have a potential for abuse less than substances in Class I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.
- Examples of Class III narcotics include products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®) and buprenorphine (Suboxone®).
- Examples of Class III non-narcotics include benzphetamine (Didrex®), phendimetrazine, ketamine and anabolic steroids such as Depo®-Testosterone.

- **Class IV controlled substances:** Substances in this class have a low potential for abuse relative to substances in Class III. Examples of Class IV substances include alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®) and triazolam (Halcion®).
- **Class V controlled substances:** Substances in this class have a low potential for abuse relative to substances listed in Class IV and consist primarily of preparations containing limited quantities of certain narcotics.
- Examples of Class V substances include cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, Phenergan with Codeine®) and ezogabine.

Cosmetic surgery: Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered family members or covered person: The employee, the employee's spouse/partner (which includes legal spouse, domestic partner and civil union partner) and/or the employee's dependent children who are covered under the Plan.

DEA Number: A DEA number is a number assigned to a health care provider (such as a medical practitioner, dentist or veterinarian) by the U.S. Drug Enforcement Administration allowing the provider to write prescriptions for controlled substances. Legally, the DEA number is solely to be used for tracking controlled substances. It is often used by the industry, however, as a general "prescriber number" that is a unique identifier for anyone who can prescribe medication.

Designated transplant facility: A facility designated by the Claims Administrator to render medically necessary covered services and supplies for qualified procedures under the Plan.

Emergency room care: The definition varies depending on your applicable Claims Administrator as follows:

Aetna:

- The treatment given in a hospital's emergency room to evaluate and treat an emergency medical condition. An emergency medical condition is a recent and severe medical condition including, but not limited to, severe pain that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, illness or injury is of such a nature that failure to get immediate medical care could result in:
  - Placing your health in serious jeopardy;
  - Serious impairment to bodily function;
  - Serious dysfunction of a body part or organ; or
  - In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Anthem BlueCross BlueShield:

- The treatment of a medical or behavioral condition of sudden onset that manifests itself by symptoms of sufficient severity (including severe pain) that a prudent layperson possessing an average knowledge of medicine and health could reasonably expect the absence of immediate medical attention to result in:
  - Placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such a person or others in serious jeopardy;
  - Serious impairment to such person's bodily function;
  - Serious dysfunction of any bodily organ or part of such person; or
  - Serious disfigurement of such person.
  - and/or other persons.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental, investigational or unproven services: This includes any medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for its proposed use.

The Claims Administrator, in its judgment, may deem an experimental, investigational or unproven service covered under the Plan for treating a life-threatening sickness or condition if it is determined by the Claims Administrator that at the time of the determination:

- Is proven to be safe with promising efficacy;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Fiduciary: A person who exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. The "named fiduciary" for the Plan is the Plans Administration Committee of Citigroup Inc., except to the extent fiduciary authority has been delegated by this document or otherwise to Claims Administrators or others.

Generic drugs: Equivalent medications that contain the same active ingredients and are subject to the same rigid FDA standards for quality, strength and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;
- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one RN or it has nursing care by an RN available; and
  - Its employees are bonded and it maintains malpractice insurance.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets all the following criteria:
  - It provides 24/7 service;
  - It is under the direct supervision of a duly qualified physician;
  - It has a nurse coordinator who is an RN with four years of full-time clinical experience (two of these years must involve caring for terminally ill patients);
  - The main purpose of the agency is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A hospice that is part of a hospital will be considered a hospice for purposes of the Plan.

Hospital: An institution engaged primarily in providing medical care to and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnoses and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
  - It continuously provides, on the premises, 24/7 nursing services by or under the supervision of registered graduate nurses; and
  - It is operated continuously with organized facilities for operative surgery on the premises.

Infertile or infertility: The condition of a presumably healthy covered person who is unable to conceive or produce conception. The Plan cover infertility treatments with a lifetime maximum.

Injury: Accidental physical harm to the body caused by unexpected external means.

Intensive care unit: A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special lifesaving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one RN in continuous and constant attendance 24/7.

Licensed counselor: A person who specializes in mental health and chemical dependency treatment and is licensed as a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Lifetime: A word appearing in the Plan in reference to benefit maximums and limitations. "Lifetime" is understood to mean the period of time in which a participant and his or her eligible dependents are covered under the Plan. Under no circumstances does "lifetime" mean during the entire lifetime of the covered individual, unless covered by the Plan at date of death.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment: Treatment for both of the following:

- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders (DSM)*, including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause; and
- Any sickness for which the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment are not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age and mobility as the covered person. For Aetna and Anthem Plans, the BMI is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared, respectively, with a co-morbid medical condition, including, but not limited to, hypertension, a cardiopulmonary condition, sleep apnea or diabetes. Please contact your Plan Administrator for additional information.

Network pharmacy: A registered and licensed pharmacy, including a mail-order pharmacy that participates in the network.

Network provider: A provider that participates in the health plan network in which you enrolled.

Non-preferred brand-name drug: A brand-name drug that is not a formulary drug. See the definition of "preferred brand-name drug."

Nurse-midwife: A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:

- Is licensed by a board of nursing as an RN; and
- Has completed a program approved by the state for the preparation of nurse-midwives.

Nurse practitioner: A person who is licensed or certified to practice as a nurse practitioner and fulfills both of these requirements:

- Is licensed by a board of nursing as an RN; and
- Has completed a program approved by the state for the preparation of nurse practitioners.

Occupational therapy: Services that improve the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored.

Other services and supplies: Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private-duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-network hospital: A hospital (as defined) that does not participate in the Plan's network in which you enrolled.

Out-of-network pharmacy: A pharmacy other than a CVS Caremark network pharmacy.

Out-of-network provider: A provider that does not participate in the Plan's network in which you enrolled.

Outpatient care: Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient, or services rendered in a physician's office, a laboratory or an X-ray facility, an ambulatory surgical center or the patient's home.

Physical therapy: Services that are designed to restore an individual to a level of function present prior to an illness or accidental injury.

Physician: A legally qualified and licensed:

- Doctor of medicine (MD);
- Doctor of chiropody (DPM, DSC);
- Doctor of chiropractic (DC);
- Doctor of dental surgery (DDS);
- Doctor of medical dentistry (DMD);
- Doctor of osteopathy (DO); or
- Doctor of podiatry (DPM).

Care provided by Christian Science practitioners is covered as an out-of-network benefit under Choice Plan.

Preadmission tests: Tests performed on a covered person in a hospital before confinement as a resident inpatient, provided the tests meet all the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a physician after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the physician and confirmed by the hospital; and
- The covered person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the covered person's condition that precludes the surgery.

Preferred brand-name drug: A drug that is prescribed from a list of medications preferred for their clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs: Any drugs that cannot be dispensed without a physician's prescription. The following will be considered prescription drugs:

- Federal legend drugs, which are any medicinal substances that the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution — federal law prohibits dispensing without prescription";
- Drugs that require a prescription under state law but not under federal law;
- Compound drugs having more than one ingredient; at least one of the ingredients has to be a federal legend drug or a drug that requires a prescription under state law;
- Injectable insulin; and
- Needles and syringes.

Primary care physician (PCP): A physician in general practice or who specializes in pediatrics, family practice or internal medicine who has agreed with the Claims Administrator to act as the entry point to the health care delivery system and may coordinate the member's care. The PCP is not an agent or employee of the Claims Administrator or Citigroup Inc.

Psychiatrist: A physician who specializes in mental, emotional or behavioral disorders.

Psychologist: A person who specializes in clinical psychology and fulfills one of these requirements:

- Is licensed or certified as a psychologist; or
- Is a member or fellow of the American Psychological Association, if there is no government licensure or certification required.

Rehabilitation facility: A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Room and board: Housing and meals, general-duty nursing, intensive nursing care by whatever name called and any other services regularly furnished by a hospital as a condition of occupancy of the class of accommodations occupied. Does not include professional services of physicians or special nursing services rendered outside an intensive care unit by whatever name called.

Self-insured or self-funded plan: A plan in which no insurance company or service plan collects premiums and assumes risk.

Sickness: Bodily disorder or disease. The term "sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility: Such a facility, if approved by Medicare, is covered by the Citigroup Health Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under applicable licensing and other laws;
- It is under the supervision of a licensed physician or RN who is devoted full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24/7 skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is authorized to administer medication to patients on the order of a licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf; a hotel; a domiciliary care home; a maternity home; or a home for alcoholics, drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Plan.

Specialty drug: A drug for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer and rheumatoid arthritis.

Treatment center: A facility that provides a program of effective mental health and chemical dependency treatment and meets all the following requirements:

- It is established and operated in accordance with any applicable state laws;
- It provides a program of treatment approved by a physician and the Claims Administrator;
- It has or maintains a written, specific and detailed regimen requiring full-time residence and full-time participation by the patient; and

- It provides at least the following basic services:
  - Room and board (to the extent that this Plan provides inpatient benefits at a treatment center);
  - Evaluation and diagnosis;
  - Counseling by a licensed provider; and
  - Referral and orientation to specialized community resources.

Treatment centers that qualify as hospitals are covered as hospitals and not as treatment centers.

Urgent care: Conditions or services that are non-preventive or non-routine and are needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment but do not require the level of care provided in an emergency room.

Urgent care facility/center: The definition varies depending on your Claims Administrator.

- **Aetna:** A hospital to which you are admitted by a physician due to:
  - The onset of or change in an illness;
  - The diagnosis of an illness; or
  - An injury.
  - **Note:** The condition, while not needing an emergency admission, is severe enough to require confinement as an inpatient in a hospital within two weeks from the date the need for the confinement becomes apparent.
- **Anthem BlueCross BlueShield:** A facility dedicated to the delivery of medical care outside a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.

Utilization review: A review and determination as to the medical necessity of services and supplies.