



About Your Health Care Benefits and Medical Plans

January 1, 2002



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Contents

Introduction	1
Eligibility	2
For employees	2
If you both work for Citigroup	3
For dependents.....	3
Dependent notification	4
Dependents no longer eligible	4
Newborns/newly adopted children	5
For domestic partners.....	5
Termination of relationship.....	7
Enrollment	8
Other coverage	8
When coverage begins	9
If you do not enroll	9
Changing your coverage	9
Changing Transportation Reimbursement Incentive Program (TRIP) contributions	10
Midyear election changes.....	10
Qualified status changes.....	10
Coverage & cost events	11
Other rules	12
Changing your coverage status	12
Your contributions	13
Before-tax contributions.....	13
Social Security taxes	14
Domestic partners	14
Tax implications	14
Coordination of benefits	15
Coordination with Medicare	16
No-fault automobile insurance.....	16
Facility of payment.....	16
Right of recovery.....	16
Release of information.....	17
Recovery provisions.....	18
Refund of overpayments	18
Reimbursement	18
Subrogation	19
When coverage ends	20
Coverage when you retire	20
Coverage if you become disabled	20

Coverage if you take a leave of absence	21
Continuing coverage during FMLA	21
Continuing coverage during military leave	22
Coverage for surviving dependents	23
COBRA	24
Who is covered	24
Your duties	25
Citigroup's duties	25
Electing COBRA	26
Duration of COBRA	26
Early termination of COBRA	27
COBRA and FMLA	27
Cost of coverage	27
Your HIPAA rights (medical only)	29
Creditable coverage	29
Your special enrollment rights	29
Claims and appeals	30
Claims and appeals for UnitedHealthcare plans	31
UnitedHealthcare level one appeal	32
UnitedHealthcare level two appeal	33
UnitedHealthcare urgent claim appeals	33
Claims and appeals for Aetna medical plans	34
Appeals for Aetna medical plans	35
External Review	35
Claims and appeals for CIGNA medical plans	37
CIGNA level one appeal	38
CIGNA level two appeal	38
CIGNA independent review procedure	39
Claims and appeals for the prescription drug program	40
Medco level one appeal	40
Medco level two appeal	41
Medco urgent claim appeals	41
Claims and appeals for MetLife PDP	42
Claims and appeals for the CIGNA Dental Care DHMO	43
CIGNA Dental level two appeal	43
CIGNA Dental expedited appeal	44
CIGNA Dental independent review	44
Appeals to the state	44
Claims and appeals for the vision care plan	45
Davis Vision level one appeal	46
Davis Vision level two appeal	47
External review	48

Special appeal process for SSB 48

ERISA information..... 49

 Answers to your questions 50

Administrative information 51

 Future of the plans 51

 No right to employment 51

 Plan administration 51

 Plan information..... 52

Introduction

This document serves as both the Summary Plan Descriptions and official plan documents (hereinafter referred to as the “SPD”) for eligible employees under the health care benefit plans for Citigroup and its participating companies. **Citigroup reserves the right to change or discontinue any or all of the benefits coverage or programs described here at any time, with or without notice.**

This SPD describes the benefits and programs, in effect as of January 1, 2002, available to Citigroup employees (hereinafter referred to as Citigroup, unless otherwise specified). The health care benefits summarized in this section describe the medical, dental and vision care plans, the Health Care and Dependent Care Spending Accounts, and the Transportation Reimbursement Incentive Program (TRIP) sponsored by Citigroup.

This SPD is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual. Your employment is always on an at-will basis. In addition, benefits under this SPD are not in any way subject to your or your dependent’s debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

This SPD is designed to be your primary source of benefits information. Refer to it for information about your benefits, and share it with your family members. As you read the SPD you will see some terms that are bold and underlined. This means that the term is a reference to another section of the SPD.

This SPD provides no guarantee that you are eligible to participate in every benefit or program described. Each plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citigroup in no way guarantees the payment of any benefit which may be or become due to any person under the plan.

If you have any questions about this SPD or certain provisions of your benefit plans, please call the Benefit Service Center at ConnectOne at 1-800-881-3938 and select the Health Benefits options.

Eligibility

Citigroup provides benefits coverage for you, your spouse or qualified domestic partner, and/or eligible dependents.

For employees

You are considered a Citigroup employee if you work for American Health and Life Company, Citibank NA and Participating Companies, CitiFinancial, Citigroup Corporate Staff, Citigroup Investment Group, CitiStreet Institutional Division, CitiStreet Total Benefit Outsourcing, Primerica Financial Services, National Benefit Life Insurance Company, or Salomon Smith Barney Holdings, Inc. and its subsidiaries.

- You are eligible to enroll in Citigroup benefits on your date of employment if you are a full-time employee (regularly scheduled to work 40 hours or more a week) of one of the participating companies of Citigroup and you receive a regular semimonthly or monthly paycheck.
- You are also eligible to enroll in Citigroup benefits on your date of employment if you are a part-time employee (regularly scheduled to work at least 20 or more hours a week) of any participating company of Citigroup. Please note that Salomon Smith Barney employees as well as Citibank employees on the Corporate and Investment Bank payroll must be regularly scheduled to work 30 or more hours a week to be eligible to enroll.
- If eligible, you also can enroll your eligible dependents for coverage as of your date of employment.
- If you are eligible to enroll in Citigroup benefits, you also can enroll your eligible dependents in the medical, dental, vision care and group life insurance plans.
- The Transportation Reimbursement Incentive Program is not available at all businesses. Please contact the Benefit Service Center for more information.

You are not eligible to participate in the health care plans if:

- Your compensation is not reported on a Form W-2 wage reporting statement issued by a participating company;
- You are employed by a Citigroup subsidiary or affiliate that is not a participating company;
- Any individuals engaged under an agreement that states they are not eligible to participate in the applicable plan or program;
- You are a non-resident alien performing services outside the U.S.; or
- You are classified by Citigroup as an independent contractor or consultant.

If you are a U.S. citizen or legal resident employed outside the U.S. or if you are otherwise unsure of whether you are eligible to participate in the health care plans, you should contact your Benefits Service Center or your local human resources department for more information.

If you both work for Citigroup

If both you and your spouse or qualified domestic partner are employed by Citigroup or a participating company, neither of you can be covered both as an employee and a dependent for *any* Citigroup benefit plan.

- **Medical, dental, and vision care** — Each of you may be covered under the medical and dental plans as either an employee or a dependent but not both. Either of you may cover your children, but they cannot be covered by both of you.
- **Health Care Spending Account** — Either of you may be covered under a Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Your qualified domestic partner and his/her eligible child(ren) are eligible, provided they are considered tax dependents under section 152 of the Internal Revenue Code (IRC).
- **Dependent Care Spending Account** — If you file a joint federal income tax return, you and your spouse together may not contribute more than \$5,000 on a before-tax basis to this account. If you are married and you and your spouse file separate federal income tax returns, the maximum you may contribute is \$2,500. Due to federal tax law, qualified domestic partners and their eligible child(ren) are not eligible to participate in a Dependent Care Spending Account.
- **Transportation Reimbursement Incentive Program Account** — Both of you may enroll for an Account, but each of you can use the account only for your own eligible expenses.

For dependents

Your eligible dependents are:

- Your lawfully married spouse or state-recognized common-law spouse;
- Each of your children who is unmarried, relies on you for financial support, and is:
 - Under the age of 19*; or
 - Under the age of 25* and a full-time student (meaning the student is enrolled in courses totaling 12 or more credits per semester) who is attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claims Administrator. The names, addresses and phone numbers of the health care Claims Administrators are listed in the **Plan information** section of this SPD.

* Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs.

A child primarily relies on you for a majority of his or her financial support if:

- You are providing more than 50% of the child's support; and
- You claim the child as a dependent on your annual tax return filed with the Internal Revenue Service (Form 1040).

Eligible dependent children are further defined as:

- Your natural children;
- Your legally adopted children (For purposes of coverage under the medical and dental plans, adopted children will be considered eligible dependents when they are placed in your home in anticipation of adoption, when primary financial support begins, or when the adoption becomes final, whichever occurs first.);
- Your stepchildren who live in your household full-time in a regular parent-child relationship; and
- A child permanently residing in your household for whom you are the legal guardian. You must provide proof of guardianship in writing to the Claims Administrator.

Eligible dependents also include an employee's domestic partner and/or his or her children, provided the children of the domestic partner meet all the other qualifications of dependent children, as described in this section. Please note that not all HMOs cover domestic partners or their children. For more specific information, contact your HMO directly.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the medical and dental plans. In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in the case of a divorce or separation. Contact the Plans Administration Committee to receive, free of charge, a detailed description of the procedures for a QMCSO.

If one of your eligible dependent children becomes incapable of self-sustaining employment due to a mental or physical disability and is covered under the medical or dental plan before reaching age 19, or age 25 if a full-time student, this child may continue to be considered an eligible dependent under the medical or dental plan beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end and as requested thereafter. This eligible dependent must still meet all other eligibility qualifications for coverage to be continued.

No person will be covered under this plan both as an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Dependent notification

The first time you enroll in Citigroup benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 19, whether the child is a full-time student or has a mental or physical disability. *Without this information on file, you cannot enroll in any dependent coverage.*

If your dependent does not have a Social Security number at this time, you can enter dependent information and report the Social Security number after you obtain it.

You also must keep your dependent information current:

- When you enroll during the annual open enrollment period, you will be prompted to make changes to your dependent information; and
- You must report changes in dependent information to the Benefit Service Center when you want to make changes to your coverage or coverage category as a result of a qualified status change.

Dependents no longer eligible

Your spouse or qualified domestic partner is eligible for coverage until the last day of the month in which you become legally separated or divorced or submit a Domestic Partnership Termination Form.

Your dependent children are eligible for coverage until the earlier of the following dates:

- The last day of the month in which they:

- Become employed full time;
- Get married; or
- Become eligible for coverage under any plan as employees;

or

- December 31 of the year in which they:
 - Reach age 19, if not full-time students (enrolled for 12 or more credits per semester at an accredited school or college) and primarily dependent on you for support, unless incapable of self-sustaining employment due to mental or physical disability;
 - Are over age 19 and stop attending school full time;
 - Reach age 25 if full-time students; or
 - Become able to support themselves after having been incapable of self-sustaining employment due to a mental or physical disability.

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citigroup will pay medical benefits for your newborn child from birth through 31 days. However, if you have Citigroup medical coverage, you must report this family status change within 31 days of the child's birth to add the child to your coverage. If you do not report the addition of your child during the first 31 days, benefits *will not* be payable for the child after the 31 days following the date of the child's birth, and you will generally have to wait until the next annual open enrollment period to enroll the child in medical coverage unless another event occurs that would permit coverage to begin at an earlier time. In this case, no payment will be made for any day of confinement, treatment, services, or supplies given to the child after these initial 31 days. No other benefit or provision of the medical plan will apply to the child.

This includes, but is not limited to, the following provisions:

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Benefit Service Center about a new dependent even if you already have family coverage, or else your new dependent won't be covered.

For domestic partners

Where available, Citigroup allows you to cover your domestic partner and/or his or her children in the following plans:

- Medical (domestic partner benefits are not available through some HMOs);
- Dental;
- Health Care Spending Account, provided your domestic partner and eligible dependent child(ren) are considered tax dependents under section 152 of the IRC;
- Group universal life (GUL) insurance for domestic partners and term life insurance for children;
- Vision care plan; and
- Business Travel Accident Insurance.

You cannot cover both a spouse and a domestic partner. To enroll a domestic partner and/or his or her children, an employee must sign an affidavit affirming that he or she meets Citigroup's eligibility criteria for domestic partner coverage, and complete a Certification of Domestic Partner's Tax Status. This form is available on Citigroup.net or by calling the Benefit Service Center.

Your domestic partner can be of the same or opposite sex. To qualify for coverage as a domestic partner, you and your domestic partner must meet all of the following criteria:

- You currently reside together and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment and intend to do so permanently;
- You have mutually agreed to be responsible for each other's common welfare;
- You are both at least 18 years of age and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage if you and your partner were of opposite sexes;
- Neither you nor your partner is legally married to another person;
- Neither you nor your partner is in a domestic partner relationship with anyone else; and
- You are in a relationship that is intended to be permanent and in which each of you is the sole domestic partner of the other.

To qualify for coverage, your domestic partner's unmarried child(ren) must be:

- The biological or adopted child of your domestic partner, a child for whom your domestic partner has legal guardianship, or a child who has been placed in your home for adoption; and
- Living with you and your domestic partner on a full-time basis, or living away at school; and
- Unmarried and under the age of 19*; or
- Unmarried and between the ages of 19 and 25* and attending school full-time; or
- Beyond age 19 and has a mental or physical disability.

* Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs.

Termination of relationship

If you have enrolled your domestic partner and his or her children for medical, dental, and/or vision care coverage and you terminate your domestic partnership, you must notify Citigroup by completing a Termination of Domestic Partnership Form within 31 days of the event. Contact the Benefit Service Center for this form. As a result, your domestic partner will be eligible to continue medical, dental, vision care, and/or Health Care Spending Account coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses and other covered dependents, excluding domestic partners and their children. See the **COBRA** section for more information.

If you enroll a partner and terminate the domestic partner relationship, you must wait six months before enrolling a new domestic partner in a medical, dental, or vision care plan sponsored by Citigroup.

Enrollment

You can enroll in Citigroup coverage within 31 days of the time you first become eligible or during the annual open enrollment period. The coverage available to you will be listed on your enrollment materials along with the enrollment deadline and how to enroll. You can enroll in any or all of the plans offered to you. For the medical and dental plans, you must choose a “coverage category.” The four coverage categories are:

- Employee only;
- Employee + child(ren);
- Employee + spouse or domestic partner; and
- Employee + family.

You can choose a different coverage category for medical and dental. For example, you might enroll in “Employee only” coverage for medical, since your spouse has medical coverage at his or her employment and “Employee + spouse” for dental coverage since your spouse’s employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your total compensation band as defined in **Your contributions**. You will find your costs in your enrollment materials.

If you elect vision care coverage, you must also designate a level of coverage (one person, two people, or three or more people). You do not need to be enrolled in the vision care plan to enroll a dependent for vision care coverage.

Other coverage

If you are eligible to enroll in coverage elsewhere, for example, through a spouse’s or other employer’s plan, you can compare the Citigroup coverage and costs with the other coverage. You may decide to enroll in some plans offered through Citigroup and some from the other source. For example, you might enroll in medical coverage elsewhere and in dental coverage from Citigroup.

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. *In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called “coordination of benefits.”* See **Coordination of benefits** for the guidelines on whose plan pays first.

When coverage begins

If:	Then:
You enroll for yourself and your eligible dependents when first eligible.	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your date of hire or date of eligibility.
You do not enroll when first eligible.	Core benefits begin on your date of hire or date of eligibility, if later. (For more information about core benefits, see <u>If you do not enroll</u> .) All other benefits will begin on January 1 of the following year, provided you enroll during the annual open enrollment period.
You enroll for yourself and your eligible dependents during the annual open enrollment period.	Coverage will begin on January 1 of the following year.
You enroll in medical, dental, vision care, and/or spending account coverage for yourself or a new dependent within 31 days of a qualified status change.	Coverage for yourself or your dependent(s) will begin on the date of the qualified status change, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

If you do not enroll

If you do not enroll in Citigroup benefits when first eligible, Citigroup will provide *only* the following coverage — known as core benefits — at no cost to you.

- Basic life and accidental death and dismemberment (AD&D) insurance equal to your total compensation, up to \$200,000, on your date of eligibility;
- Short-term disability (STD) coverage to replace your annual base salary for an approved disability leave of up to 13 weeks. The percentage of salary replacement (100% or 60%) will depend on your length of service. Your annual base salary at the start of your disability leave will be used to calculate your benefit. You are not eligible for a salary increase during an approved STD leave.
- Basic long-term disability (LTD) coverage, if your total compensation is \$50,000 or less, to replace 60% of total compensation, up to \$50,000 in total compensation starting on the 92nd day of an approved disability. Total compensation is determined on your date of eligibility and then annually each following year. This coverage amount will be in effect for the calendar year unless your total compensation decreases due to a change in status from full-time to part-time employment or because you begin to receive LTD benefits.

Changing your coverage

During the year, you may want to change your coverage or coverage category. Citigroup has specific rules about when you can change your coverage.

For medical, dental, and vision care coverage and the Health Care and Dependent Care Spending Accounts — the coverages you pay for with before-tax dollars — you can make changes only during the open enrollment period or as a result of certain events, such as marriage, the birth or adoption of a child, divorce, or the death of a dependent. These events are called qualified status changes. You must make any qualified status change-related changes to your coverage within 31 days of the event. See **Qualified status changes**.

Type of coverage:	When you can change your coverage or coverage category:
Medical and dental	The annual open enrollment period or within 31 days of a qualified status change. Note: You can change your medical or dental plan election only as a result of your relocation out of your medical or dental plan's service area.
Vision care	The open enrollment period or within 31 days of a qualified status change. Note: When you enroll for vision coverage, you will not be able to change coverage for two years.
Health Care and Dependent Care Spending Accounts	The annual open enrollment period or within 31 days of a qualified status change.

Changing Transportation Reimbursement Incentive Program (TRIP) contributions

You may enroll in, change (increase or decrease) your contribution amounts, or end contributions to a TRIP account at any time. Any changes made mid-year to your TRIP account(s) will be effective on the first day of the following month.

Midyear election changes

The federal government recently clarified the rules that govern when you can change benefit coverage elections outside of open enrollment. These rules apply to coverage elections you make for your medical, dental, vision care, and spending accounts coverages. In general, the benefit plans and coverage levels you choose at open enrollment remain in effect for the following calendar year. However, you may be able to change your elections between annual enrollment periods if you have a qualified status change or other applicable event, as further explained below.

Qualified status changes

The following is a list of qualified status changes that will allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status.** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment;
- **Domestic partnership status.** You enter into or terminate a domestic partnership;
- **Number of dependents.** Any event that changes your number of tax dependents, including birth, death, adoption, and placement for adoption;
- **Employment status.** Any event that changes your, your spouse's, or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or terminating employment;
 - A strike or lockout;
 - Starting or returning from an unpaid leave of absence;
 - Changing from part-time to full-time employment or vice versa; and
 - A change in work location.
- **Dependent status.** Any event that causes your tax dependent to become eligible or ineligible for coverage because of age, student status, or similar circumstances;

- **Residence.** A change in the place of residence for you, your spouse, or another dependent if outside your medical or dental plan's network service area.

Consistency requirements

The changes you make to your medical, dental, vision care, and spending account coverages must be "due to and consistent with" your qualified status change. To satisfy the federally required "consistency rule," your qualified status change and corresponding change in coverage must meet both of the following requirements.

Effect on eligibility

Except for the Dependent Care Spending Account, the qualified status change must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified status change results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

For the Dependent Care Spending Account, the qualified status change must affect the amount of dependent care expenses eligible for reimbursement. For example, your child reaches age 13, and dependent care expenses are no longer eligible for reimbursement.

Corresponding election change

The election change must correspond with the qualified status change. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel medical coverage only for that dependent. Additionally, you may decrease or end contributions to a Health Care Spending Account or a Dependent Care Spending Account if you have or adopt a child or a child is placed with you for adoption. The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage & cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below.

Coverage events

Medical and dental coverage: If Citigroup adds or eliminates a plan option in the middle of the plan year, or if Citigroup-sponsored coverage is significantly limited or ends, you and your eligible dependents can elect different coverage in accordance with Internal Revenue Service (IRS) regulations.

For example, if there is an overall reduction under a plan option that reduces coverage to participants in general, participants enrolled in that plan option may elect coverage under another option providing similar coverage (if the other plan option permits). Additionally, if Citigroup adds an HMO or other plan option midyear, participants can drop their existing coverage and enroll in the new plan option (if the new plan option permits). You and/or your eligible dependents may also enroll in the new plan option even if not previously enrolled for coverage at all (if the new plan option permits).

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Citigroup), you may make a corresponding midyear election change. This rule applies to the medical, dental, and vision care plans, as well as the Dependent Care Spending Account.

If another employer's plan allows your spouse or other dependent to change his or her elections in accordance with IRS regulations, you may make a corresponding midyear election change to your coverage.

You may increase, decrease, or end contributions to a Dependent Care Spending Account if you gain coverage under another plan. Similarly you may enroll for or increase contributions to a Dependent Care Spending Account if you lose coverage under another plan.

You may not decrease or end Health Care Spending Account contributions or enroll for a Dependent Care Spending Account when your spouse becomes eligible for coverage under another plan. You may not end Health Care Spending Account contributions if you become eligible for coverage under another plan.

Dependent Care Spending Account: If your dependent care provider reduces or increases the number of hours worked, you may make a corresponding change to your Dependent Care Spending Account election. For example, if your child starts school, causing a reduction in the number of hours he or she is in the care of a dependent care provider, you may decrease your Dependent Care Spending Account election.

Cost events

You must contact Citigroup within 31 days of a cost event. Otherwise, your next opportunity to make changes will be the next enrollment period or when you have a qualified status change or other applicable event, whichever occurs first.

Medical and dental coverage costs: If your cost for medical, dental, or vision care coverage increases or decreases significantly during the year, you may make a corresponding election change. For example, you may elect another plan option with similar coverage, or drop coverage if no coverage is available. Additionally, if there is a significant decrease in the cost of a plan during the year, you may enroll in that plan, even if you declined to enroll in that plan earlier.

Any change in the cost of your plan option that is *not* significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Dependent Care Spending Account: If you change your dependent care provider midyear, you may change your Dependent Care Spending Account contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates midyear, you may increase or decrease your contributions.

Other rules

Medicare or Medicaid entitlement: You may change an election for medical coverage midyear if you, your spouse, or your eligible dependent becomes entitled to, or loses entitlement to, coverage under Part A or Part B of Medicare, or under Medicaid. However, you are limited to reducing your medical/dental coverage only for the person who becomes entitled to Medicare or Medicaid, and you are limited to adding medical/dental coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act: You may drop medical (including the Health Care Spending Account), dental, and vision care coverage midyear when you begin an unpaid leave, subject to the provisions of the Family and Medical Leave Act (FMLA). If you drop coverage or if you fail to make payments for benefit coverage during your FMLA leave, when you return from the FMLA leave, you have the right to be reinstated to the same elections you made prior to taking your FMLA leave.

Special note regarding domestic partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a qualified domestic partner. However, IRS rules generally do not permit you to make a midyear change "on a *before-tax* basis" for such events unless they involve a *tax* dependent. Thus, if you make a midyear change due to an event involving your domestic partner, that change must generally be made "on a *post-tax* basis," unless your domestic partner can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your domestic partner makes an election change under his or her employer's plan in accordance with IRS regulations.) Please see IRS Publication 17, *Your Federal Income Tax*, for a discussion of the definition of a tax dependent. The publication is available at www.irs.gov/formspubs/index.html.

Changing your coverage status

You must make changes to your health benefits *within 31 days* of a qualified status change by calling the Benefit Service Center. The change will be effective on the date of your status change.

Your contributions

Your contributions for medical, dental, and vision care are based on the plan chosen and the coverage category. Your medical contribution also depends on your total compensation and which total compensation band applies to you. The compensation bands for 2002 are shown in the table below. Contributions for your Health Care and Dependent Care Spending Accounts and Transportation Reimbursement Incentive Program are determined by your contribution amount.

Total compensation bands on which employee contributions for medical coverage are based:
\$20,000 or less
\$20,001 – \$25,000
\$25,001 – \$40,000
\$40,001 – \$60,000
\$60,001 – \$80,000
\$80,001 – \$100,000
\$100,001 – \$150,000
\$150,001 – \$200,000
\$200,001 – \$300,000
\$300,001 – \$500,000
More than \$500,000

For purposes of calculating your medical cost and coverage amounts, total compensation is determined each year and will apply for the entire calendar year. For 2002, your total compensation includes the following:

- Base pay plus shift differential paid for 2000;
- Commissions paid for 2000;
- Bonus paid for 2000, excluding any Annual Incentive Bonus for 1999; and
- 2000 Annual Incentive Bonus (paid in early 2001).

Your total compensation amount will apply for the entire calendar year.

If you are a part-time employee, your base pay plus shift differential will be calculated on an annualized basis. The formula will be your hourly rate of pay (including shift differential) X 52 weeks X 20 hours, regardless of the number of hours you are actually scheduled to work.

If you were hired or rehired in 2002 or you change your employment status from full-time to part-time or vice versa, your base pay and shift differential generally will be annualized as of your date of hire or the effective date of your change in status. For more specific information, contact your Benefits Service Center.

Before-tax contributions

When you choose coverage that requires a payroll contribution, most of your contributions are made with before-tax dollars. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. Contributions may, however, be subject to state or local income taxes in certain jurisdictions.

Social Security taxes

Each year you pay Social Security taxes on a certain level of your earnings, called the taxable wage base. Since the before-tax dollars you use for some of your plan contributions are not considered part of your pay for Social Security tax purposes, your Social Security taxes will also be reduced if your pay falls below the taxable wage base after these before-tax dollars are subtracted from your total earnings. In this case, your future Social Security benefit may be smaller than if after-tax dollars were used for those purposes.

Domestic partners

The cost of coverage for a domestic partner is the same as the cost for a spouse. The cost of coverage for a domestic partner's child(ren) is the same as the cost for a dependent child. For the cost of domestic partner coverage in a particular plan, call the Benefit Service Center.

If your domestic partner and his or her child(ren) qualify as your dependents under section 152 of the IRC, your contributions for domestic partner medical, dental, and/or vision care coverage will be taken before taxes are withheld. However, if your partner and his or her child(ren) do not qualify as dependents under section 152, you will pay for their medical, dental, and/or vision care coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your domestic partner in Citigroup coverage.

If your domestic partner does NOT qualify as a tax dependent: If your domestic partner and his or her child(ren) do not satisfy the definition of a dependent under section 152 of the IRC, the cost of any medical, dental, and/or vision care coverage for your domestic partner and/or his or her child(ren) is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income.

If your domestic partner qualifies as a tax dependent: If your domestic partner and his or her child(ren) qualify as dependents under section 152 of the IRC, your contributions for their medical, dental, and/or vision care coverage will be taken before taxes are withheld, and there are no tax implications for you.

Since the tax requirements are complex, you should consult a tax professional for advice on your personal situation.

Generally, a member of your household qualifies as your tax dependent under the IRC if:

- You provide more than 50% of his or her financial support;
- The individual lives with you for the entire year; and
- The individual is a citizen or resident of the United States.

To review the qualifications of a section 152 dependent, see IRS Publication 17, *Your Federal Income Tax*, at www.irs.gov/formspubs/index.html.

Coordination of benefits

Coordination of benefits provisions apply to the medical and dental plans only and are described in this section.

All payments under the plans described in this SPD will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under this plan will be determined. One of the plans involved will pay benefits first — the primary plan — and the other plan(s) will pay benefits next — the secondary plan(s).

The following definitions apply to terms used in this section:

- **Allowable expense:** Includes any necessary, reasonable, and customary expense that would be covered in full or in part under the Citigroup plan. When an HMO provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.
- **Plan:** Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured), medical care components of group long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or other governmental benefits, as permitted by law.
- **Primary plan:** A benefit plan that has primary liability for a claim.
- **Secondary plan:** A benefit plan that adjusts its benefits by the amount payable under the primary plan.

The Citigroup plan will be the primary plan on claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children, the birthdays of the parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage (For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your children). If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

When the Citigroup plan is the primary plan, it will pay benefits first. Benefits will be calculated according to the terms of the plan and will not be reduced due to benefits payable under other plans.

When the Citigroup plan is the secondary plan, benefits under the Citigroup plan may be reduced. The Claims Administrator will determine the amount the Citigroup plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citigroup plan would have normally paid. The Citigroup plan will pay you the difference. If the Citigroup plan is secondary, you will never be paid more for the same expenses under both the Citigroup plan and the primary plan than the Citigroup plan would have paid alone.

When the Citigroup plan is secondary and the patient is covered under an HMO, benefits under the Citigroup plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO.

When a child is claimed as a dependent by parents who are separated or divorced, the primary plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. Otherwise, the Citigroup plan will be secondary. When a child's parents are separated or divorced and there is no court decree, then benefits will be determined in the following order:

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child.

In the event that a legal conflict exists between two plans as to which is primary and which is secondary, the plan that has covered the patient for the longer time will be considered primary. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered primary.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and are covered under the Citigroup plan, the Citigroup plan continues to be the primary plan. The Citigroup plan is primary for the following situations:

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citigroup plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- Social Security disabled participants who are covered by the Citigroup plan on the basis of your active employment status with Citigroup and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

If you are entitled to Medicare and want Medicare as your primary coverage, you must decline Citigroup medical coverage. From that point forward, Medicare will be your only coverage, and no benefits will be provided by the Citigroup plan.

If you or a covered family member becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

No-fault automobile insurance

In states with no-fault automobile insurance, the automobile insurance carrier is the primary insurance for injuries resulting from an automobile accident. All medical expenses related to the automobile accident should be submitted to the automobile insurance carrier first. The Citigroup plan will pay covered expenses not payable under the no-fault automobile insurance according to the coordination of benefit rules discussed above.

Facility of payment

When benefit payments that would have been made under a Citigroup plan have been made under another plan, the Citigroup plan has the right to pay the other plan the amount that satisfies the intent of the provision. Any payment made will be considered payment of benefits under the Citigroup plan and, to the extent of such payments, the Citigroup plan's obligation to pay benefits will be satisfied.

Right of recovery

The Citigroup plan has the right to recover any payment made in excess of the maximum amount payable under this provision. The Citigroup plan may recover from one or more of the following entities in an effort to make the plan whole:

- Any persons it paid or for whom payment was made;

- Any insurer, and any other organization; or
- Any entity that was thereby enriched.

Release of information

Certain facts are needed to apply the rules of this provision. The Claims Administrator has the right to decide which facts are needed. The Claims Administrator may get the needed facts from or give them to any other organization or person. The Claims Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claims Administrator will determine the information necessary to operate this provision.

Citigroup will use and disclose health care information that relates to plan participants only as appropriate for plan administration and only as permitted by applicable law.

Recovery provisions

Recovery provisions apply to the medical and dental plans and are described in this section.

Refund of overpayments

Whenever payments have been made by the plan with respect to covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the plan's provision, the covered person(s) must make a refund to the plan in the amount paid in excess of the amount payable under the plan and help the plan obtain the refund from another person or organization.

If the covered person(s) or any other person or organization that was paid does not promptly refund the full amount, the plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount it should have paid. In the case of recovery from a source other than the plan, the refund equals the amount of recovery up to the amount paid under the plan. The plan may have other rights in addition to the right to reduce future benefits.

Reimbursement

This section applies when a covered person recovers damages, by settlement, verdict, or otherwise, for an injury, sickness, or other condition. If the covered person has made, or in the future may make, such a recovery, including a recovery from an insurance carrier, the plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.

However, if the plan does pay or provide benefits for such an injury, sickness, or other condition, the covered person – or the legal representatives, estate, or heirs of the covered person – will promptly reimburse the plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdicts, or insurance proceeds received by the covered person (or by the legal representatives, estate, or heirs of the covered person) to the extent that medical benefits have been paid for or provided by the plan to the covered person.

If the covered person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the covered person has received benefits from the plan, the plan must be reimbursed first. In other words, the covered person's recovery from a third party may not compensate the covered person fully for all of the financial expenses incurred because acceptance of benefits from the plan constitutes an agreement to reimburse the plan for any benefits the covered person receives.

The covered person also must take any reasonably necessary action to protect the plan's subrogation and reimbursement right. That means by accepting benefits from the plan, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action, or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party. The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also agrees that the Plan Administrator may withhold any future benefits paid by this plan or any other disability or health plan maintained by Citigroup or its participating companies to the extent necessary to reimburse this plan under the plan's subrogation or reimbursement rights.

In order to secure the rights of the plan under this section, the covered person hereby:

- Grants to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by the covered person to the extent of all benefits provided in an effort to make the plan whole; and
- Assigns to the plan any benefits the covered person may have under any automobile policy or other coverage. The covered person shall sign and deliver, at the request of the plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.

The covered person will cooperate with the plan and its agents and will:

- Sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of reimbursement;
- Provide any relevant information; and
- Take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the value of the benefits provided.

If the covered person does not sign and deliver any such documents for any reason (including but not limited to the fact that the covered person was not given an agreement to sign or is unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the plan. If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the plan's right of reimbursement.

Subrogation

This section applies when another party is, or may be considered, liable for a covered person's injury, sickness, or other condition (including insurance carriers who are so liable) and the plan has provided or paid for benefits.

The plan is subrogated to all the rights of the covered person against any party liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits provided to the covered person under the plan. The plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the plan under this section.

The costs of legal representation retained by the plan in matters related to subrogation shall be borne solely by the plan. The costs of legal representation retained by the covered person shall be borne solely by the covered person.

When coverage ends

Your coverage automatically will terminate on the earliest of the following dates:

- The date the Citigroup plan terminates;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which you retire, you die, or you otherwise cease to be eligible for coverage.
- The date benefits paid on behalf of a participant equal the lifetime maximum benefit under the Citigroup plan. Coverage for eligible dependents who have not reached their lifetime maximum will not be affected.

Your eligible dependent's coverage automatically will terminate on the earliest of the following dates:

- Midnight of the last day of the month in which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage. Coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. Coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job;
- The date the eligible dependent(s) is covered as an employee under the plan;
- The date the eligible dependent(s) is covered as the dependent of another employee under the plan;
- The date the eligible dependent(s) enters the armed forces of any country or international organization; or
- The date the dependent is no longer eligible for coverage under a QMCSO.

You and your eligible covered dependents may be able to continue coverage under COBRA. See **COBRA** for more information.

Coverage when you retire

You are eligible for retiree health care coverage if you are at least age 55 with at least 10 years of service when you retire. Coverage will continue for each covered person until that person becomes eligible for Medicare. You will be required to contribute to the cost of coverage.

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care plan coverage and participation in the Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions. After you have been disabled for 13 weeks, if you are still disabled and/or long-term disability coverage is pending, your coverage will remain in effect.

If you are totally disabled and receiving long-term disability benefits, coverage will continue as follows.

Medical coverage will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions. After that, you may continue medical coverage by making the same contributions as active employees, based on your length of service as shown in the table below.

Length of service	Continuation period for medical coverage
Less than two years	Six months
Two years to less than five years	Equal to length of service
Five years or more	As long as you are disabled or until you reach normal retirement age of 65

At the end of the period, you may continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Dental coverage will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Vision care coverage will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Health Care Spending Account participation will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA.

Dependent Care Spending Account and the Transportation Reimbursement Incentive Program account participation end as of the day you become disabled.

Coverage if you take a leave of absence

If you are on an approved leave of absence, call the Benefit Service Center about your rights to continue medical, dental, vision care and/or spending account coverage.

Continuing coverage during FMLA

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are eligible for FMLA, you may take up to a total of 13 weeks of leave each calendar year (except where state law mandates differently).

If you take an unpaid leave of absence that qualifies under FMLA, medical, dental, and vision care coverage for you and your dependents and your participation in the Health Care Spending Account may continue as long as you continue to contribute your share of the cost of coverage during the leave.

Note that your monthly contributions during a leave are made on an after-tax basis.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may reenroll when you return from your leave. Your coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave, you will be entitled to purchase COBRA continuation coverage for your medical, dental, vision and Health Care Spending Account benefits. If your employment is terminated while you are on an FMLA leave, you may also be eligible to continue your insurance coverage under COBRA.

During an FMLA leave, you have access to the entire amount of your Health Care Spending Account annual election, less any prior reimbursements that you have received, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave or electing to increase your contribution level to “make up” for the contributions you missed during your leave. If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave. Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

Continuing coverage during military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage (including medical, dental, vision, and Health Care Spending Account) for up to 18 months as long as you give Citigroup advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from Citigroup, does not exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both company and employee contributions) necessary to cover an employee who does not go on military leave. Your other benefits will be terminated at the beginning of your military leave.

If you take a military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plans Administration Committee determines whether an exclusion or waiting period applies once you are reinstated to the plan.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave, you may be entitled to purchase continuation coverage for the remaining months, up to a total of 18 months.

Coverage for surviving dependents

When an active employee dies, his or her surviving covered spouse and/or dependent children may be eligible for continued coverage.

- If the employee was not eligible for retiree health care coverage at the time of death, medical and dental coverage will continue for the surviving spouse and/or dependent children for six months at no cost. After the six-month period, they will be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period.
- If the employee was eligible for retiree health care coverage at the time of death, the surviving spouse and/or dependent children will be eligible for retiree health care coverage on the same terms as a retired employee.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end (called “qualifying events”). The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. Citigroup reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the plan.

You will have to pay the entire premium plus a 2% administrative fee for your continuation coverage. There is a grace period of at least 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

Who is covered

If you are covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period.

If you are the spouse of an employee and are covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Citigroup-sponsored group health plan for any of the following four reasons:

- The death of your spouse;
- The termination of your spouse’s employment (for reasons other than your spouse’s gross misconduct) or reduction in your spouse’s hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare.

If you are a covered dependent child of an employee covered by a Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following five reasons:

- The death of the employee;
- The termination of the employee’s employment (for reasons other than the employee’s gross misconduct) or reduction in the employee’s hours of employment;
- The employee’s divorce or legal separation;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be a “dependent child” under the Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citigroup of the birth or adoption.

If the covered employee fails to notify Citigroup in a timely fashion (in accordance with the terms of the Citigroup-sponsored group health plans), the covered employee will *not* be offered the option to elect COBRA coverage for the child. Newly acquired dependents (other than children born to, adopted by, or placed for adoption with the employee) will not be considered qualified beneficiaries but may be added to the employee's continuation coverage.

Separate Elections: Each qualified dependent has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified dependent who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects.

Your duties

Under the law, the employee or a family member has the responsibility to inform Citigroup of a divorce, legal separation, or a child losing dependent status under the Citigroup-sponsored medical, dental, or vision care plans, or Health Care Spending Account. This notice *must* be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event).

If the employee or a family member fails to provide this notice to Citigroup during this 60-day notice period, any family member who loses coverage will *not* be offered the option to elect continuation coverage. The notice must be in writing. Send the notice to:

Citigroup Service Center
P.O. Box 785004
2300 Discovery Drive
Orlando, FL 32878.

When Citigroup is notified that one of these events has happened, Citigroup in turn will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Citigroup and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Citigroup's duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage:

- The employee's death or termination (for reasons other than gross misconduct),
- A reduction in the employee's hours of employment, or
- The employee's entitlement to Medicare.

Electing COBRA

To elect or inquire about COBRA coverage, contact the Benefit Service Center.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described earlier, or, if later, 60 days after Citigroup provides you notice of your right to elect continuation coverage. *An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.*

If you choose continuation coverage, Citigroup is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect.

These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You should notify Citigroup if a second qualifying event occurs during your continuation coverage period.

When coverage ends, generally you can't convert your coverage to an individual medical policy. However, some HMOs do offer conversion to individual coverage. Contact your HMO directly.

Special Rules for Disability: The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified dependents due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified dependent must inform Citigroup within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified dependent is no longer disabled, the individual must inform Citigroup of this redetermination within 30 days of the date it is made, at which time the 11-month extension will end.

If a qualified beneficiary is disabled and another qualifying event occurs within the 29-month continuation period, then the continuation coverage period is 36 months after the termination of employment or reduction in hours.

Medicare: If you lose coverage (medical, dental, or vision care plan, or Health Care Spending Account) due to your termination of employment or reduction in hours, your covered family member's COBRA coverage will not end before 36 months from the date you become covered by Medicare.

Early termination of COBRA

The law provides that your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- Citigroup no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid on time (within the applicable grace period);
- The qualified dependent becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any preexisting condition of the individual;
- The qualified dependent becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the disability carrier that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Citigroup that you are not returning at the end of the leave; or
- The end of the leave, assuming you do not return to work.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave.

Cost of coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, Citigroup will notify you of any changes in the cost.

The initial payment for continuation coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days.

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA administrator at the address listed below. Also, if your marital status has changed, or you, your spouse or a dependent have changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the plan, you must notify the COBRA administrator in writing immediately at the address listed below.

All notices and other communications regarding COBRA and the Citigroup-sponsored group health plan should be directed to:

ADP COBRA Services
P.O. Box 27478
Salt Lake City, UT 84127-0478

Or you may call 1-800-422-7608.

Your HIPAA rights (medical only)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

HIPAA restricts the ability of group health plans to exclude coverage for preexisting conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described below.

Creditable coverage

Under HIPAA, when you and your dependents no longer have Citigroup medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a preexisting condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Your special enrollment rights

If you decline to enroll for Citigroup medical coverage for yourself and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citigroup coverage *provided that you request enrollment within 31 days after the date your coverage ends because you or a family member loses eligibility under another plan or because COBRA coverage has ended*. In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you also may be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you will have to wait until the next open enrollment period — or have another qualified status change or special enrollment right — to enroll.

To meet IRS regulations and plan requirements, Citigroup reserves the right at any time to request written documentation of any dependent's eligibility for plan benefits and/or the effective date of the qualifying event.

Claims and appeals

To receive benefits from most of the Citigroup benefit plans, you will need to file a claim.

Medical

- For all plans other than HMOs
 - Use one of the following forms available on Citigroup.net:
 - 301 – Aetna Medical Claim Form (for Managed Choice POS plan participants);
 - 302 – CIGNA Point of Service Claim Form (for FlexCare POS plan participants);
 - 303 – UnitedHealthcare Claim Form (for Select Plus POS, Health Plan 2000, Health Plan 200, and Out-of-Area Plan participants);
 - Based on your business group you may obtain forms through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
- HMO participants
 - Call your HMO for any claim-filing information.

Prescription Drug

- Claim Form
 - Available from www.medcohealth.com or by calling Medco Health customer service at 1-800-987-8369.

Dental

- MetLife 75 with Preferred Dentist Program (PDP)
 - Use Form 304 – MetLife Dental Claim form available on Citigroup.net.
 - Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
 - CIGNA Dental Care DHMO
 - There are no claim forms to file under this plan.

Vision Care Plan

- Call Davis Vision at 1-800-999-5431 or visit www.davisvision.com.

Health Care Spending Account and Dependent Care Spending Account

- Use Form 305 Spending Account Reimbursement Request Form available on Citigroup.net.
 - Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.

Transportation Reimbursement Incentive Program

- File TRIP Claim Form (Form 306) for reimbursement.
 - Claim forms are available on Citigroup.net, the TRIP Service Center at 1-800-378-1823, the TRIP Web site at www.trip.adpfsa.com.
 - Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.

All claims for benefits must be filed within certain time limits.

- Medical, dental, and vision care claims must be filed within two years of the date of service.
- Health Care Spending Account and Dependent Care Spending Account claims must be filed by June 30 of the calendar year following the year in which the expense was incurred.
- Transportation Reimbursement Incentive Program claims must be filed by April 1 of the calendar year following the year in which the expense was incurred.

Claims and appeals for UnitedHealthcare plans

As of July 1, 2002, the amount of time UnitedHealthcare will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring notification 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 the claim was improperly filed and how to correct the filing must be given within five days Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring notification 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
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision for all other claims made within 15 days for pre-service claims and 30 days for post-service claims

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

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

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

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claims Administrator.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim, contact Customer Service immediately.

UnitedHealthcare level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

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.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

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 decision on your appeal as follows:

- For appeals of pre-service 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 appeal of a denied claim.
- 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 appeal of a denied claim.

UnitedHealthcare level two appeal

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

For appeals of pre-service claims, 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 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.

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

If you are an employee of Salomon Smith Barney Holdings, Inc., and its subsidiaries, please see **Special appeal process for SSB**.

UnitedHealthcare 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, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for Aetna medical plans

As of July 1, 2002, the amount of time Aetna will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

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

Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

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

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

Appeals for Aetna medical plans

Except for urgent care claims, you will have 180 days following receipt of a claim denial to appeal the decision, if the claim was filed on or after July 1, 2002. You will be notified of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your identification card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claims Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

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.

External Review

An "External Review" is a review by independent physician, with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna appeal process for denied claims, as outlined in this ***Claims and appeals for Aetna medical plans*** section of this SPD and you have received a final denial;
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds \$500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the External Review Request Form (except under expedited review as described below), a copy of the plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision with 30 calendar days of Aetna's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the plan, except where Aetna or the plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

If you are an employee of Salomon Smith Barney Holdings, Inc., and its subsidiaries, please follow the appeal process described below.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the review procedures.

You may request a review of the denied claim. The request must be submitted in writing within 60 days after you receive the notice. Include your reasons for requesting the review. Submit your request to the office of Aetna to which you submitted your initial request for benefit payment.

Your claim will be reviewed by the plan's fiduciary and ordinarily you will be notified of the final decision within 60 days of receipt of your request. If special circumstances require an extension of time, you will be notified of such extension during the 60 days following receipt of your request.

Claims and appeals for CIGNA medical plans

As of July 1, 2002, the amount of time CIGNA will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

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

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

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

The CIGNA medical plans have a two-step appeals procedure for coverage decisions. To appeal the denial of a claim, you must submit a request for an appeal in writing to CIGNA within 180 days after receiving notice of the denial of your claim. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card. You may also register your appeal by an arranged appointment or walk-in interview.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claims Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

CIGNA level one appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, CIGNA will respond in writing with a decision within 15 calendar days after receiving an appeal for a pre-service or concurrent coverage determination, and within 30 calendar days after receiving an appeal for a post-service coverage determination. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- Your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

CIGNA level two appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Appeals Committee. For appeals involving medical necessity or clinical appropriateness, the committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by the CIGNA Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals CIGNA will acknowledge in writing that your request was received and will schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within 15 calendar days; for post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Appeal Committee to complete the review. You will be notified in writing of the Appeal Committee's decision within five business days after the committee meeting, and within the committee review time frames above if the Appeal Committee does not approve the requested coverage.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

If you are an employee of Salomon Smith Barney Holdings, Inc., and its subsidiaries, please see **Special appeal process for SSB**.

CIGNA independent review procedure

If you are not fully satisfied with the decision of CIGNA's level two appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

Generally, there is no charge for you to initiate this independent review process. However, you must provide written authorization permitting CIGNA to release the information to the independent reviewer selected.

CIGNA will abide by the decision of the independent review organization.

For more information about CIGNA's independent review procedure, contact CIGNA. You may also contact your state's Department of Insurance for assistance.

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the CIGNA appeals procedure. You may not initiate a legal action against CIGNA until you have completed the level one and level two appeals processes.

Claims and appeals for the prescription drug program

As of July 1, 2002, the amount of time Medco will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

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

Claim forms may be obtained at your place of employment. These forms tell you how and when to file a claim.

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

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

Medco level one appeal

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

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

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

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 decision on your appeal as follows:

- For appeals of pre-service 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 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 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.

Medco level two appeal

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

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

If you are an employee of Salomon Smith Barney Holdings, Inc., and its subsidiaries, please see **Special appeal process for SSB**.

Medco 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, we have delegated to the Claims Administrator the exclusive right to interpret and administer the provisions of the plan. The Claims Administrator's decisions are conclusive and binding.

Claims and appeals for MetLife PDP

As of July 1, 2002, the amount of time MetLife will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

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

If a claim for benefits is denied in whole or in part, the claimant will be notified in writing by an Explanation of Benefits Statement or a denial letter from MetLife within 60 days of the denial. You have the right to request a reconsideration of the denied claim by calling or writing MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If after the review it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If after the review it is determined that the original denial stands, a denial letter is written.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- Explanation of why the charges are denied in plain language
- Reference to the plan (booklet) wording which justifies the denial

The appeal request must be submitted in writing to MetLife within 60 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claims Management and, a Dental Consultant. The plans provide that the committee has the authority and discretion to interpret the plans' provisions and to determine eligibility under the plans to receive benefits. The determination of the committee will be made in a fair and consistent manner in accordance with its interpretation of the plan's terms.

The committee will issue a decision on the case no later than the third meeting of the committee after receipt of the appeal request. The committee usually meets monthly. This decision is sent to the claimant in writing and includes the specific reasons and references to the plan provision on which the decision is based.

If you are an employee of Salomon Smith Barney Holdings, Inc., and its subsidiaries, please see **Special appeal process for SSB**.

Claims and appeals for the CIGNA Dental Care DHMO

To initiate an appeal, you must submit a request in writing to the CIGNA Dental Plan within one year from the date of the initial CIGNA Dental decision or occurrence. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your request when you call.

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

CIGNA Dental will respond with a decision within 30 calendar days after your request is received. If the review cannot be completed within 30 days, CIGNA Dental will notify you on or before the 30th day of the reason for the delay. The review will be completed within 15 calendar days after that.

- For New Jersey residents, CIGNA Dental will respond in writing within 15 working days;
- For Colorado residents, CIGNA Dental will respond within 20 working days; and
- For Nebraska residents, CIGNA Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a second-level review. To initiate a level two appeal, you must submit your request in writing to CIGNA Dental within 60 days after receipt of CIGNA Dental's level one decision.

CIGNA Dental level two appeal

Second-level reviews will be conducted by CIGNA Dental's Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the appeals committee. For appeals involving dental necessity or clinical appropriateness, the committee will include at least one dentist. If specialty care is in dispute, the committee will consult with a dentist in the same or similar specialty as the care under consideration, as determined by CIGNA Dental.

CIGNA Dental will acknowledge your appeal in writing within five business days and schedule a committee review. The acknowledgment will include the name, address, and telephone number of the appeals coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your situation to the committee in person or by conference call. Please advise CIGNA Dental five days in advance if you or your representative plans to be present. You will be notified in writing of the committee's decision within five business days after the committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

CIGNA Dental expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the plan will respond orally with a decision within 72 hours, followed up in writing within two business days of the decision.

- For Maryland residents, CIGNA Dental will respond within 24 hours; and
- For Texas residents, CIGNA Dental will respond within one business day.

CIGNA Dental independent review

If your appeal concerns a dental necessity issue and the appeals committee denies coverage, you may request that your appeal be referred to an independent review organization. To request a referral to an independent review organization, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Administrative, eligibility, or benefit coverage limits are not eligible for additional review under this process.

There is no charge to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental to release the information to the independent reviewer selected. The independent review organization is composed of persons who are not employed by CIGNA Dental or any of its affiliates. CIGNA Dental will abide by the decision of the independent review organization.

To request a referral to an independent review organization, you must notify the appeals coordinator within 60 days of your receipt of the appeals committee's level two appeal review denial. CIGNA Dental will then forward the file to the independent review organization within 30 days.

The independent review organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the plan's dental director, the review shall be completed within three to five days.

The independent review program is a voluntary program arranged by the plan and is not available in all areas.

Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

CIGNA Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Claims and appeals for the vision care plan

As of July 1, 2002, the amount of time Davis Vision will take to make a decision on a claim will depend on the type of claim.

Type of claim	For claims filed on or after July 1, 2002
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 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*
Pre-service claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

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

You have the right to voice a grievance or complaint against Davis Vision at any time. Davis Vision will not retaliate or take any discriminatory action against you because you have filed a grievance, complaint or appeal. A grievance is a complaint that may or may not require specific corrective action and is made:

- Via the telephone;
- In writing to Davis Vision; or
- Via the Davis Vision Web site.

Claims include but are not limited to the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;
- Difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, "adverse determination."

You may file a grievance by

- contacting Davis Vision's toll free hot line 24 hours a day at 1-800-584-1487;
- sending a letter via U.S. mail or overnight delivery; or
- logging on to the Web site: www.davisvision.com.

Written grievances should be sent to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attention: Quality Assurance/Patient Advocate Department

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

You will be contacted by a Davis Vision associate within five business days of receipt of a concern or grievance to confirm that the concern was received and is being investigated. A designated Davis Vision associate will review the appeal with you and may request additional information. You will be provided with the Associate's name, phone number, department and the estimated time needed to perform the research (for pre-service appeals, 15 days; for post-service appeals, 30 days) and when you can expect a determination. You will also be informed of your right to have a representative, including your provider, present during the review of the concern and final outcome of the investigation. You also will be informed of your right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions, the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point-of-service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. When further information is required, Davis Vision will contact you and inform you of the status of the investigation and/or the need for more information.

At the conclusion of the investigation, the determination will be communicated within 15 days for pre-service claims and 30 days for post-service claims, or as required by state statute, (or an additional 10 days may be requested in order to complete further research). The appeal determination will include the following:

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including the documentation supporting the decision;
- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;
- Copy of the appeals process, if applicable; and
- Name, position, phone number and department of the person(s) who was responsible for the outcome.

The decision of the Quality Assurance/Patient Advocate Department is final and binding unless you appeal to Davis Vision within 15 business days of the date of notice of the decision.

Davis Vision level two appeal

Should Davis Vision uphold a denial, as the result of a level one review, you have the right to request a level two appeal.

A level two appeal will not include any associate(s) or licensed (peer) health care professional(s) that were involved in the level one review.

A level two appeal requires you to contact Davis Vision in writing or by telephone within 15 days following your receipt of the level one summary statement.

If you are requesting a level two appeal, you must indicate the reason you believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to solicit further information from you and/or the provider.

Davis Vision has 35 days, or as required by state statute, from the date the requested information is received, to respond to the level two review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within 35 days. Notification will include, but may not be limited to:

- The outcome of the investigation and a summary stating the nature of the concern and the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including documentation that was used to support the decision;
- A statement indicating that the decision will be final and binding unless you appeal in writing or by telephone to the Quality Assurance/Patient Advocacy Department within 45 days of the date of the notice of the level two decision;
- A copy of the appeals process, if applicable; and
- The name, position, phone number and department of person(s) who was responsible for the outcome.

External review

Davis Vision gives you, as required by state statute, an opportunity to request an impartial review of concerns that resulted in coverage denials. If you have utilized and exhausted the internal appeals process, you may appeal the final decision if the denial for services exceeds \$250 and was not deemed medically necessary or the requested service was deemed investigational or experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organization will have up to 30 days, or as required by state statute, to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that each state has implemented an external review process that is unique to their residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. You can call the Member Service Department at 1-800-999-5431 for information unique to your state of residence. You also have the right to contact your state insurance or health department for further information.

You have the right to an external review of a denial of coverage. You have the right to an external review of a final adverse decision under the following circumstances:

- You have been denied a vision care service, which should have been covered under the terms of the vision care plan;
- Services were denied on appeal on the basis that requested services were not medically necessary;
- A treatment or service that will have a significant positive impact on you has been denied and any alternative service or treatment will not affect your ocular health and/or will produce a negative outcome;
- The services denied are related to a current illness or injury;
- The cost of the requested services will not exceed that of any equally effective treatment;
- The denied service, procedure, or treatment is a covered benefit under the vision care plan; or
- You have exhausted all internal appeal processes with an adverse determination upheld at each level.

The vision care provider may contact the appropriate state agency to determine if other documentation may be required for the appeal process.

The external review representative must make a decision within 30 days of receipt of documentation, or as required by state statute, and notifies you within two business days of a determination. Notification must be in writing and include an explanation and the clinical criteria utilized in the decision.

Special appeal process for SSB

Employees of Salomon Smith Barney Holdings, Inc. and its subsidiaries should file a level two appeal with the SSB Benefits committee by sending a written appeal to:

Salomon Smith Barney Benefits Committee
Employee Benefits Department
388 Greenwich Street, 6th Floor
New York, NY 10013

ERISA information

As a participant in Citigroup benefit plans, you have rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all plan documents (including group insurance policies where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration) such as annual reports (Form 5500 Series) and plan descriptions. You can review these documents at no cost to you at the location of the plan sponsor.

You may obtain copies of all plan documents and other plan information upon written request to the Plans Administration Committee. The Plans Administration Committee may charge a reasonable fee for copying the documents.

You may receive a copy of the plan's annual financial reports upon written request to the Plans Administration Committee.

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and all other documents governing the plan on the rules governing your continuation coverage rights.

You can reduce or eliminate an exclusionary period of coverage for preexisting conditions under your group health plan (if one exists), if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer:

- When you lose coverage under the plan;
- When your continuation coverage ceases, if you request it before losing coverage; or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for plan participants, ERISA imposes obligations on plan fiduciaries, the people responsible for the operation of an employee benefit plan. Under ERISA, fiduciaries must act prudently and solely in the interest of plan participants and their beneficiaries. No one, including your employer or any other person, may fire you or discriminate in any way against you to prevent you from obtaining a pension benefit or for exercising your rights under ERISA.

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. For more information see the **Claims and appeals** section.

Under ERISA, there are steps you can take to enforce the rights described above. For example, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plans Administration Committee to provide the materials and pay you up to \$110 a day until you receive them, unless the materials were not sent for reasons beyond the Plans Administration Committee's control.

If your claim for benefits is denied or ignored, in full or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a qualified medical child support order, you may file suit in federal court. If you believe the plan fiduciaries are misusing their authority under the plan or if you believe you are being discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or file a suit in federal court.

The court will decide who should pay court costs and legal fees. If your suit is successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. One instance in which you may be required to pay court costs and legal fees is if the court found your suit to be frivolous.

Answers to your questions

If you have questions about the plan, contact the Plans Administration Committee. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plans Administration Committee, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. The Pension and Welfare Benefits Administration's New York City branch is located at 1633 Broadway, Room 226, New York, NY 10019. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Pension and Welfare Benefits Administration or by accessing the Web site at www.dol.gov/pwba.

Administrative information

This section contains general information about the administration of the Citigroup plans, the plan documents, sponsors, and Claims Administrators. In addition, a statement about the future of the plans and Citigroup's right to amend, modify, suspend, or terminate is outlined in this section.

Future of the plans

The plans are subject to various legal requirements. If changes are required for continued compliance, you will be notified.

Citigroup has the right to amend, modify, suspend, or terminate any plan, in whole or in part, at any time without prior notice. Citigroup may make any such amendment, modification, suspension, or termination of the plans.

In the event of the dissolution, merger, consolidation or reorganization of Citigroup, the plan will terminate unless the plan is continued by a successor to Citigroup.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law, unless otherwise stated in the applicable plan document.

No right to employment

Nothing in this SPD represents or is considered an employment contract, and neither the existence of the plan nor any statements made by or on behalf of Citigroup shall be construed to create any promise or contractual right to employment or to the benefits of employment. Citigroup or you may terminate the employment relationship without notice at any time and for any reason.

Plan administration

Citigroup is the plan sponsor.

The Plan Administrator is responsible for the general administration of the plan, and will be the fiduciary to the extent not otherwise specified in this document or in an insurance contract. The Plan Administrator and the Claims Administrator have the discretionary authority to construe and interpret the provisions of the plans and make factual determinations regarding all aspects of the plans and their benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The plan has designated other organizations or persons to act out specific fiduciary responsibilities in administering the plan including, but not limited to, any or all of the following responsibilities:

- To administer and manage the plan, including the processing and payment of claims under the plan and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the plan; and
- To act as Claims Administrator and to review claims and claim denials under the plan to the extent an insurer or administrator is not empowered with such responsibility.

The Plan Administrator will administer the plan on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of New York will be controlling in all matters relating to the plan.

This SPD is intended to provide you with accurate and easy-to-understand information about your Citigroup benefits and summaries of the information you need to use your benefits.

Plan information

Employer Identification Number	52-1568099
Participating Companies	American Health and Life Company, CitiFinancial, Citigroup Corporate Staff, Citigroup Investment Group, Primerica Financial Services, and National Benefit Life Insurance Company, Citibank NA and Participating Companies, CitiStreet Institutional Division, and CitiStreet Total Benefit Outsourcing, Salomon Smith Barney Holdings Inc. and its subsidiaries
Plan Names and Numbers	
<ul style="list-style-type: none"> ▪ Medical plans (self-funded POS, Health Plan 2000, Health Plan 200, Out-of-Area Plan, and HMOs) including prescription drugs 	Citigroup Health Benefit Plan Plan number 508
<ul style="list-style-type: none"> ▪ Dental plans 	Citigroup Dental Benefit Plan Plan number 505
<ul style="list-style-type: none"> ▪ Vision care plan 	Citigroup Vision Benefit Plan
<ul style="list-style-type: none"> ▪ Health Care and Dependent Care Spending accounts 	Citigroup Flexible Benefits Plan Plan number 512
<ul style="list-style-type: none"> ▪ Transportation Reimbursement Incentive Program 	Citigroup Transportation Reimbursement Incentive Program
Plan Sponsor	Citigroup Inc. 1 Court Square, 15 th Floor Long Island City, NY 11120
Claims Administrators	
<p>Each of the Claims Administrators has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of their respective health care benefit plan — namely, those provisions of the SPD that apply to the participant and administered by that particular Claims Administrator.</p>	
For POS plans	Aetna Citibank Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 CIGNA HealthCare P. O. Box 36125 Charlotte, NC 28236 1-800-794-4953 UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845

For self-insured HMO plans	Aetna P. O. Box 16408 Pittsburgh, PA 15242 1-800-821-3808 CIGNA HealthCare P. O. Box 36125 Charlotte, NC 28236 1-800-794-4953 UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7854
For Health Plan 2000, Health Plan 200, and Out-of-Area Plan	UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7854
For Prescription Drug Program	
<ul style="list-style-type: none"> ▪ Retail Pharmacy 	Medco Health Prescription Solutions, Inc. P. O. Box 2187 Lee's Summit, MO 64063-2187
<ul style="list-style-type: none"> ▪ Home Delivery Service Pharmacy 	Medco Home Delivery Pharmacy Service, Inc. P. O. Box 182050 Cincinnati, OH 43218-2050
For Dental Plans	
<ul style="list-style-type: none"> ▪ MetLife 75 with Preferred Dentist Program (PDP) 	Metropolitan Life Insurance Company MetLife Dental Claims Unit P. O. Box 14093 Lexington, KY 40512-4093 1-888-832-2576
<ul style="list-style-type: none"> ▪ CIGNA Dental Care DHMO 	CIGNA Dental/Member Services 300 NW 82 nd Avenue Suite 700 Plantation, FL 33324 1-800-367-1037
For Vision Care Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
For Health Care and Dependent Care Spending Accounts	UnitedHealthcare FSA Service Center P. O. Box 981178 El Paso, TX 79998-1178 1-877-311-7845; prompt 2
For Transportation Reimbursement Incentive Program	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693

Agent for Service of Legal Process	Citigroup Inc. General Counsel 399 Park Avenue, 3 rd Floor New York, NY 10043
Plan Year	January 1 – December 31
Funding	With the exception of the vision care plan, the CIGNA DHMO, and the many fully insured HMOs, all plans are paid from the general assets of Citigroup, providing benefits for medical expenses. The vision care plan and the CIGNA DHMO are funded through an insurance contract. The cost of all plans is shared by Citigroup and the participant.
Type of Administration	The plans are administered by the Plans Administration Committee. However, final decision on the payment of claims rest with the Claims Administrators, with the exception of Salomon Smith Barney Holdings, Inc. Benefits are paid from the general assets provided by the Plan Sponsor and may be from a trust qualified under section 501(c)(9) of the Internal Revenue Code on behalf of the plans in accordance with the terms of their contracts. The Claims Administrators do not guarantee the benefits under the plan.

Notice required by the Florida Insurance Department: Some of these plans are self-insured group health plans not regulated by the Florida Insurance Department. Payment of claims is completely dependent upon the financial solvency of the employer or other entity sponsoring the plans. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or plan sponsor cannot pay.



Medical Plans

January 1, 2002

Contents

Introduction	1
Point-of-Service plan	2
UnitedHealthcare Select Plus	3
Network coverage	5
Out-of-network coverage	7
Mental health/chemical dependency	9
No medical necessity (except for mental health/chemical dependency benefits)	11
Medically necessary — mental health/chemical dependency benefits	11
Aetna Managed Choice	12
Network coverage	14
Out-of-network coverage	16
Mental health/chemical dependency	18
Medically necessary	20
Retrospective Record Review	20
Concurrent Review and Discharge Planning	21
CIGNA POS	21
Network coverage	23
Out-of-network coverage	25
Mental health/chemical dependency	27
Medically necessary	29
Health Plan 2000 (UnitedHealthcare)	30
How the Plan works	31
Deductible and coinsurance	31
Out-of-pocket maximum	31
Routine care	32
Infertility	32
Hospital	33
Emergency care	33
Urgent care	33
Mental health/chemical dependency	33
Coverage levels	34
Inpatient services	34
Outpatient services	35
Emergency care	35
No medical necessity (except for mental health/chemical dependency benefits)	35
Medically necessary — mental health/chemical dependency benefits	35

Out-of-Area Plan (UnitedHealthcare).....	36
How the Plan works	37
Deductible and coinsurance.....	37
Out-of-pocket maximum.....	37
Routine care	37
Infertility	38
Hospital	39
Emergency care	39
Urgent care	39
Mental health/chemical dependency	39
Coverage levels	40
Inpatient services	40
Outpatient Services.....	41
Emergency care	41
No medical necessity (except for mental health/chemical dependency benefits).....	41
Medically necessary — mental health/chemical dependency benefits	41
Health Maintenance Organization(s)	42
UnitedHealthcare EPO	43
How the UnitedHealthcare EPO Plan works.....	44
Prescription drugs	47
Mental health/chemical dependency.....	49
Aetna HMO	51
How the Aetna HMO Plan works	52
Prescription drugs	56
Mental health/chemical dependency.....	58
Retrospective Record Review.....	59
Concurrent Review and Discharge Planning	59
CIGNA HMO	60
How the CIGNA HMO Plan works	61
Routine Care	63
Prescription drugs	65
Mental health/chemical dependency.....	67
Health Plan 200 — Hawaii Only.....	69
How the Plan works	70
Deductibles and coinsurance	70
Out-of-pocket maximum.....	70
Routine care	71
Infertility	71
Hospital	72

Emergency care	72
Urgent care	72
Mental health/chemical dependency	72
Coverage levels	73
Inpatient services	74
Outpatient services	74
Emergency care	74
No medical necessity (except for mental health/chemical dependency benefits).....	74
Medically necessary — mental health/chemical dependency benefits	74
Prescription drug program.....	75
Retail pharmacy.....	76
Using a network pharmacy.....	76
Using an out-of-network pharmacy.....	76
Home delivery pharmacy service	77
Covered drugs	77
Drugs not covered	78
Precertification/notification	80
UnitedHealthcare plans — Care Coordination Program	80
Notification	80
Non-notification penalty.....	81
Inpatient confinements.....	81
Outpatient surgery/diagnostic testing/other services	81
Mental health/chemical dependency.....	82
Organ/tissue transplants	82
Pregnancy	82
Aetna plans	83
Non-precertification penalty	83
Inpatient confinements.....	83
Outpatient surgery/diagnostic testing.....	84
Mental health/chemical dependency.....	84
Organ/tissue transplants	84
Pregnancy	85
CIGNA plans	85
Non-precertification penalty	85
Inpatient confinements.....	86
Outpatient surgery/diagnostic testing.....	86
Mental health/chemical dependency.....	87
Organ/tissue transplants	87
Pregnancy	87

Covered services and supplies	89
Acupuncture	89
Ambulatory surgical center	89
Anesthetics.....	89
Baby care	89
Birth center	89
Cancer detection	90
Chemotherapy.....	90
Contraceptive services/devices	90
Dietitian/nutritionist.....	90
Durable medical equipment	90
Foot care	91
Hearing aids	91
Home health care.....	91
Hospice care	92
Hospital services	92
Infertility treatment.....	93
Laboratory tests/x-rays.....	94
Licensed counselor services	94
Medical care.....	94
Medical supplies.....	94
Medical transportation services	95
Nurse-midwife	95
Nurse-practitioner.....	95
Oral surgery/dental services	95
Organ/tissue transplants	95
Orthoptic training	98
Outpatient occupational therapy	98
Outpatient physical therapy	98
Preferred brand-name drug	98
Prescribed drugs	98
Private-duty nursing care	98
Psychologist services.....	98
Radiation Therapy.....	99
Rehabilitation Therapy	99
Skilled nursing facility services	100
Speech therapy	100
Spinal manipulations	100
Surgery.....	100

Termination of pregnancy 101
Treatment centers 101
Voluntary sterilization 101
Well-child care 101
Wellness benefit 101
Women’s Health and Cancer Rights Act of 1998 102
Exclusions and limitations 103
Glossary 109

Introduction

This section of the SPD/plan document describes your Citigroup health benefits under the medical plans as of January 1, 2002. Citigroup has entered into arrangements with UnitedHealthcare, Aetna, and CIGNA HealthCare (collectively the "Health Plans"), which provide for the Health Plans to process medical benefit claims and provide certain other services. UnitedHealthcare, Aetna, and CIGNA HealthCare do not insure the benefits described in this summary.

The Citigroup Inc. Medical Benefits Plan offers several medical options to protect you and your eligible dependents against the high cost of treating major illness and injury. Depending on your location, you may choose from:

- Point-of-Service plans (UnitedHealthcare Select Plus, Aetna Managed Choice and CIGNA POS);
- Health Plan 2000 (UnitedHealthcare);
- Out-of-Area Plan (UnitedHealthcare);
- Health Maintenance Organization (HMO) Plans (UnitedHealthcare uses the term "Exclusive Provider Organization" or EPO. In Wisconsin, the CIGNA HMO is called the CIGNA EPO.); or
- Health Plan 200 (UnitedHealthcare, available in Hawaii only).

This section of the SPD should be read in combination with the **About Your Health Care Benefits** section, which provides you with information about plan eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details. As you read the SPD, you will see some terms that are bold and underlined. This means that the term is a reference to another section of this SPD.

This section of the SPD is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual.

Point-of-Service plan

A Point-of-Service (POS) plan combines features of managed care plans with those of traditional indemnity plans. It is called a “Point-of-Service” plan because at the point you need medical care, you can choose a provider inside or outside the plan’s network of providers. Citigroup offers three POS plans:

- UnitedHealthcare Select Plus;
- Aetna Managed Choice (in select locations); or
- CIGNA POS (available in Florida only).

Employees in some areas of the United States have a choice between two POS plan options.

The following sections describe the features of each POS plan. Be sure to read the sections that apply to the plan available to you.

UnitedHealthcare Select Plus

Type of service	Network	Out-of-network
Annual deductible		
▪ Individual	▪ None	▪ \$500
▪ Maximum per family	▪ None	▪ \$1,000
Annual out-of-pocket maximum (includes deductible)		
▪ Individual	▪ None	▪ \$3,000
▪ Maximum per family	▪ None	▪ \$6,000
Lifetime maximum	▪ None	▪ None
Professional care (in office)		
▪ PCP visits	▪ \$15 copayment	▪ 70% of R&C after deductible
▪ Specialist visits	▪ \$25 copayment	▪ 70% of R&C after deductible
▪ Allergy treatment	▪ 100% after copayment; no copayment if office visit fee is not charged	▪ 70% of R&C after deductible
Routine care (subject to frequency limits)		
▪ Well adult	▪ 100% after copayment	▪ 70% of R&C, no deductible, up to \$250 annually
▪ Well-child and immunizations	▪ 100% after copayment	▪ 70% of R&C, no deductible
▪ Routine vision exams	▪ 100% after copayment, limited to one exam every 24 months	▪ Not covered
▪ Routine hearing exams	▪ 100% after copayment, limited to one exam every 24 months	▪ Not covered
Hospital inpatient and outpatient		
▪ Semi-private room and board, doctor's charges, lab, x-ray, and surgical care	▪ 100%	▪ 70% of R&C after deductible; notification required for hospitalization, facility admissions, and certain outpatient procedures and services
Maternity care		
▪ Physician office visit	▪ 100% (copayment applies for initial prenatal visit)	▪ 70% of R&C after deductible
▪ Hospital delivery	▪ 100%	▪ 70% of R&C after deductible

Type of service	Network	Out-of-network
Emergency care (no coverage if not a true emergency)		
<ul style="list-style-type: none"> ▪ Hospital emergency room 	<ul style="list-style-type: none"> ▪ \$50 copayment, waived if admitted for any reason within 24 hours 	<ul style="list-style-type: none"> ▪ \$50 copayment, waived if admitted for any reason within 24 hours
<ul style="list-style-type: none"> ▪ Urgent care facility 	<ul style="list-style-type: none"> ▪ \$15 copayment 	<ul style="list-style-type: none"> ▪ \$15 copayment
Outpatient lab and x-ray services	<ul style="list-style-type: none"> ▪ 100% 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible
Outpatient short-term rehabilitation		
Physical, speech, or occupational therapy	<ul style="list-style-type: none"> ▪ \$25 copayment per office visit, up to 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out-of-network services combined. 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible, up to 60 visits per year for physical, speech, and occupational therapy combined. This limit applies to network and out-of-network services combined.
<ul style="list-style-type: none"> ▪ Chiropractic therapy 	<ul style="list-style-type: none"> ▪ \$25 copayment per visit, up to 20 visits per year for network and out-of-network services combined 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible, up to 20 visits per year for network and out-of-network services combined
Durable medical equipment (includes orthotics/prosthetics and appliances)	<ul style="list-style-type: none"> ▪ 100% 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible (notification required if equipment is more than \$1,000)
Home health care	<ul style="list-style-type: none"> ▪ 100%, limited to 40 visits annually for network and out-of-network services combined 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible, limited to 40 visits annually for network and out-of-network services combined
Hospice	<ul style="list-style-type: none"> ▪ 100% 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible
Skilled nursing facility	<ul style="list-style-type: none"> ▪ 100% (limited to 120 days annually for network and out-of-network services combined) 	<ul style="list-style-type: none"> ▪ 70% of R&C after deductible (limited to 120 days for network and out-of-network services combined)
Infertility treatment	<ul style="list-style-type: none"> ▪ Covered up to \$8,000 per calendar year for medical benefits with a lifetime maximum of \$24,000 ▪ Prescriptions covered up to a \$2,500 annual pharmacy maximum with a lifetime maximum of \$7,500 ▪ Contact UnitedHealthcare for specific coverage. 	
Prescription drugs (refer to Prescription drug program)		
Mental health and chemical dependency (refer to Mental health and chemical dependency)		

This chart is intended as a brief summary of benefits. Not all covered services, exclusions and limitations are shown. For additional information and/or clarification of benefits, see **Covered services and supplies** and **Exclusions and limitations**.

Network coverage

To receive the highest level of benefits from UnitedHealthcare Select Plus, referred to as the network level of benefits, you must use a network provider. You do not need to obtain a referral from your primary care physician (PCP).

Primary care physician (PCP)

Your primary care physician (PCP) is the coordinator of your and your covered dependent's medical care, excluding treatment provided through the **mental health and chemical dependency** program. Your copayment will be \$15 for each PCP office visit.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in UnitedHealthcare Select Plus is available directly from UnitedHealthcare at 1-877-311-7845 or online at **www.provider.uhc.com/citigroup**.

Specialists

If you need the services of a specialist, you will receive the network level of benefits when you receive care from any network provider. You do not need to obtain a referral from your PCP. The copayment for a specialist's office visit is \$25.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment. If you receive an allergy injection only (without a physician office visit charge), you will not be required to pay a copayment. If services are for other than an allergy injection, the specialist copayment of \$25 will apply. If services are obtained from your PCP and you are charged for an office visit, the primary care physician copayment of \$15 will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% for covered services after the applicable copayment.

Routine care

UnitedHealthcare Select Plus offers preventive care services and health screenings to help detect health problems early. The following are covered at 100% for covered services after a copayment for each doctor's office visit.

- **Routine physical exam:** well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines or as directed by the PCP. For frequency guidelines, call UnitedHealthcare.
- **Routine health screenings:**
 - Gynecological exam including a Pap smear performed by a network provider annually;
 - Mammogram with no copayment, unless there is an associated doctor's office visit, at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy

- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older;
- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist;
- **Routine hearing exam:** one exam every 24 months, performed by a network otolaryngologist or otologist.

Infertility

UnitedHealthcare Select Plus covers medical *and* pharmacy expenses associated with infertility treatment. The infertility benefit covers:

- Medical expenses up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000; and
- Prescription drug expenses associated with infertility treatment up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

These coverage limits include infertility treatment in-network and out-of-network and across all UnitedHealthcare plans combined. Coverage for prescription drugs used to treat infertility is provided through the **Prescription drug program**. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

In order to be eligible for infertility benefits, you or your eligible dependent must have a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

For more specific information, contact UnitedHealthcare directly.

Hospital

Hospital care (inpatient and outpatient) coordinated through your PCP or network specialist is covered at 100% for covered services. If you use a network provider but are *not* referred by your PCP or by a network physician, you will be reimbursed at the out-of-network level based on the negotiated rate contracted with the Claims Administrator. Services provided by a network physician in an out-of-network hospital will be reimbursed at the out-of-network level.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital within 24 hours for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility; and if you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact the PCP or a \$500 penalty may apply. See **Precertification/notification**.

Non-emergency services provided in the emergency room are not covered under UnitedHealthcare Select Plus unless you are referred by your PCP.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on UnitedHealthcare's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Charges not covered

A network provider contracts with UnitedHealthcare to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under UnitedHealthcare Select Plus or not approved by the plan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the POS plan and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see [Claims and appeals for UnitedHealthcare plans](#).

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under UnitedHealthcare Select Plus. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see [Claims and appeals for UnitedHealthcare plans](#).

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible (\$500 individual/\$1,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the \$500 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the \$1,000 family deductible, but no one person can apply more than the individual deductible (\$500) toward the family deductible amount.

Once you have met the deductible, UnitedHealthcare normally pays 70% of reasonable and customary (R&C) charges for covered expenses that are received out-of-network.

Out-of-pocket maximum

The individual out-of-pocket maximum for services rendered outside of the network is \$3,000 (\$6,000 family maximum). This amount includes the \$500 individual (\$1,000 family) deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed reasonable and customary (R&C) expenses, penalties, any coinsurance charges for mental health/chemical dependency services, or services not covered under UnitedHealthcare Select Plus. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of R&C for the remainder of the calendar year.

Eligible 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 (\$3,000) to the family out-of-pocket maximum (\$6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed R&C;
- Pharmacy expenses;
- Any coinsurance charges for mental health/chemical dependency services;
- Charges for services not covered under the POS plan; and
- Any expense that would have been reimbursed if you had notified UnitedHealthcare Select Plus.

In addition, expenses incurred when using network services do not count toward your out-of-network, out-of-pocket maximum.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at 70% of R&C for covered services, subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines; adult exams are limited to \$250 annually. For frequency guidelines, call UnitedHealthcare.
- **Routine health screenings** (based on AMA guidelines):
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy as part of a routine physical; and
 - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men ages 50 and older.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

UnitedHealthcare Select Plus covers medical *and* pharmacy expenses associated with infertility treatment. The infertility benefit covers:

- Medical expenses up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000; and
- Prescription drug expenses associated with infertility treatment up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

These coverage limits include infertility treatment in-network and out-of-network and across all UnitedHealthcare plans combined. Coverage for prescription drugs used to treat infertility is provided through the **Prescription drug program**. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

In order to be eligible for infertility benefits, you or your eligible dependent must have a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

For more specific information, contact UnitedHealthcare directly.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of R&C, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Notification is required for hospitalization, facility admissions, and certain outpatient procedures and services. For more information, see **Precertification/notification**.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital within 24 hours for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact UnitedHealthcare within 48 hours. If you are unable to do this, have a family member contact UnitedHealthcare.

If you or your family member fail to contact UnitedHealthcare, you will pay a \$500 penalty. In addition, your hospitalization will not be covered at the network level of reimbursement. See **Precertification/notification**.

Non-emergency services provided in an emergency room are not covered.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on UnitedHealthcare's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Mental health/chemical dependency

UnitedHealthcare Select Plus provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call UnitedHealthcare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call UnitedHealthcare before seeking treatment for mental health or chemical dependency treatment. A directory of participating providers is available directly from UnitedHealthcare at 1-877-311-7845 or online at **www.provider.uhc.com/citigroup**.

Action	Inpatient	Outpatient
If you call UnitedHealthcare and use its network provider/facility	No deductible, eligible expenses covered at 100% of the negotiated rate; maximum benefit of 30 days per calendar year*	No deductible, \$25 copayment per visit; maximum benefit of 52 visits per calendar year*
If you call UnitedHealthcare but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you do not call and do not use UnitedHealthcare's network provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Unlike the medical benefits under UnitedHealthcare Select Plus, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage limitations and deductibles that are required under UnitedHealthcare Select Plus. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under UnitedHealthcare Select Plus.

Mental health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

No benefit will be paid for services that are not considered to be medically necessary. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You must notify UnitedHealthcare Select Plus of inpatient services or a \$500 penalty may apply to each occurrence. UnitedHealthcare Select Plus pays benefits at the network level if you call the plan and use a network provider. If you do not use a network provider, you will be reimbursed at 70% of R&C after the deductible is met. You do not need a referral from your PCP for any mental health/chemical dependency care you may require.

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. There is a maximum benefit of 30 days per calendar year for inpatient mental health/chemical dependency services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by UnitedHealthcare in advance of the admission.

Outpatient services

You are encouraged to call UnitedHealthcare for outpatient referrals, although a referral is not required. If you call UnitedHealthcare and use a network provider, you will make a \$25 copayment for each visit. If you use an out-of-network provider, you will be reimbursed at 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call UnitedHealthcare within 48 hours after the emergency care is given. UnitedHealthcare's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you should call UnitedHealthcare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights chart.

No medical necessity (except for mental health/chemical dependency benefits)

UnitedHealthcare Select Plus provides coverage based on the benefits described in this summary plan description. There is no determination of medical necessity.

Medically necessary — mental health/chemical dependency benefits

UnitedHealthcare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. UnitedHealthcare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless UnitedHealthcare's behavioral health provider determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about coverage for a particular service or supply or limits that may apply, see **Covered services and supplies** or contact UnitedHealthcare at 1-877-311-7845.

Remember that you and your family members always have the choice of what kind of medical care to get, as well as which provider to use and where to receive care — regardless of what UnitedHealthcare Select Plus covers.

Aetna Managed Choice

Type of service	Network	Out-of-network
Annual deductible		
▪ Individual	▪ None	▪ \$500
▪ Maximum per family	▪ None	▪ \$1,000
Annual out-of-pocket maximum (includes deductible)		
▪ Individual	▪ None	▪ \$3,000
▪ Maximum per family	▪ None	▪ \$6,000
Lifetime maximum	▪ None	▪ None
Professional care (in office)		
▪ PCP visits	▪ \$15 copayment	▪ 70% of R&C after deductible
▪ Specialist visits	▪ \$25 copayment	▪ 70% of R&C after deductible
▪ Allergy treatment	▪ 100% after copayment; no copayment if office visit fee is not charged	▪ 70% of R&C after deductible
Routine care (subject to frequency limits)		
▪ Well adult	▪ 100% after copayment	▪ 70% of R&C, no deductible, up to \$250 annually
▪ Well-child and immunizations	▪ 100% after copayment	▪ 70% of R&C, no deductible
▪ Routine vision exams	▪ 100% after copayment, limited to one exam every 24 months	▪ Not covered
▪ Routine hearing exams	▪ 100% after copayment, limited to one exam every 24 months; referral required	▪ Not covered
Hospital inpatient and outpatient		
▪ Semi-private room and board, doctor's charges, lab, x-ray, and surgical care	▪ 100%	▪ 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures

Type of service	Network	Out-of-network
Maternity care		
<ul style="list-style-type: none"> Physician office visit 	<ul style="list-style-type: none"> 100% (copayment applies for initial prenatal visit) 	<ul style="list-style-type: none"> 70% of R&C after deductible
<ul style="list-style-type: none"> Hospital delivery 	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Emergency care (no coverage if not a true emergency)		
<ul style="list-style-type: none"> Hospital emergency room 	<ul style="list-style-type: none"> \$50 copayment, waived if admitted for any reason within 24 hours 	<ul style="list-style-type: none"> \$50 copayment, waived if admitted for any reason within 24 hours
<ul style="list-style-type: none"> Urgent care facility 	<ul style="list-style-type: none"> \$15 copayment 	<ul style="list-style-type: none"> \$15 copayment
Outpatient lab and x-ray services	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Outpatient short-term rehabilitation		
<ul style="list-style-type: none"> Physical, speech, or occupational therapy 	<ul style="list-style-type: none"> \$25 copayment per office visit, up to 60 visits per year for all types of therapy 	<ul style="list-style-type: none"> 70% of R&C after deductible, up to 60 visits per year for all types of therapy
<ul style="list-style-type: none"> Chiropractic therapy 	<ul style="list-style-type: none"> \$25 copayment per visit, up to 20 visits per year 	<ul style="list-style-type: none"> 70% of R&C after deductible, up to 20 visits per year
Durable medical equipment (includes orthotics/prosthetics and appliances)	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Home health care	<ul style="list-style-type: none"> 100%, limited to 40 visits annually for network and out-of-network services combined 	<ul style="list-style-type: none"> 70% of R&C after deductible, limited to 40 visits annually for network and out-of-network services combined
Hospice	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Skilled nursing facility	<ul style="list-style-type: none"> 100% (limited to 120 days annually for network and out-of-network services combined) 	<ul style="list-style-type: none"> 70% of R&C after deductible (limited to 120 days for network and out-of-network services combined)
Infertility treatment	<ul style="list-style-type: none"> Prescriptions covered up to a \$2,500 annual pharmacy maximum with a lifetime maximum of \$7,500 (covered through the Prescription drug program) Aetna Managed Choice only covers diagnosis and treatment of underlying causes of infertility 	
Prescription drugs (refer to <u>Prescription drug program</u>)		
Mental health and chemical dependency (refer to <u>Mental health/chemical dependency</u>)		

This chart is intended as a brief summary of benefits. Not all covered services, exclusions and limitations are shown. For additional information and/or clarification of benefits, see **Covered services and supplies** and **Exclusions and limitations**.

Network coverage

To receive the highest level of benefits from Aetna Managed Choice, referred to as the network level of benefits, you must receive care from your primary care physician (PCP) or have a referral from your PCP to obtain additional care within the network.

Primary care physician (PCP)

Your primary care physician (PCP) is the coordinator of your and your covered dependent's medical care, excluding treatment provided through the **mental health and chemical dependency** program. Your copayment will be \$15 for each PCP office visit.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in Aetna Managed Choice is available directly from Aetna Managed Choice at 1-800-545-5862 or online at **www.aetna.com**.

Specialists

If you need the services of a specialist, your PCP will refer you to a network specialist for treatment. The copayment for a specialist's office visit is \$25. Further treatment from the specialist will be coordinated through your PCP.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment. If you receive an allergy injection only (without a physician office visit charge), you will not be required to pay a copayment. If services are for other than an allergy injection, the specialist copayment of \$25 will apply. If services are obtained from your PCP and you are charged for an office visit, the primary care physician copayment of \$15 will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% for covered services after the applicable copayment.

Routine care

Aetna Managed Choice offers preventive care services and health screenings to help detect health problems early. The following are covered at 100% for covered services after a copayment for each doctor's office visit. Care must be provided or referred by your PCP, except where noted below.

- **Routine physical exam:** well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines or as directed by the PCP. For frequency guidelines, call Aetna.
- **Routine health screenings:**
 - Gynecological exam including a Pap smear performed by a network provider annually. A referral from your PCP is not required. Any follow-up or related care also may be provided directly by your network gynecologist;
 - Mammogram with no copayment, unless there is an associated doctor's office visit, at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;

- Colonoscopy
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older;
- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist; PCP referral is required;
- **Routine hearing exam:** one exam every 24 months, performed by a network otolaryngologist or otologist; PCP referral is required.

Infertility

Aetna Managed Choice covers only the diagnosis and treatment of underlying causes of infertility. Medical infertility coverage is not offered; however, coverage for infertility prescription drugs is provided through the **Prescription drug program**, up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500. These limits are in addition to any other prescription drug limits or requirements.

For more specific information, contact Aetna directly.

Hospital

Hospital care (inpatient and outpatient) coordinated through your PCP or network specialist is covered at 100% for covered services. If you use a network provider but are *not* referred by your PCP or by a network physician, you will be reimbursed at the out-of-network level based on the negotiated rate contracted with the Claims Administrator. Services provided by a network physician in an out-of-network hospital will be reimbursed at the out-of-network level.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

Emergency care does not require a referral from your PCP before services are rendered, as long as your visit is a true emergency as defined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact the PCP or a \$500 penalty may apply. See **Precertification/notification**.

When emergency care has ended, you must get a referral from your PCP before receiving any additional services. If you or your dependent does not get a referral as required, benefits are payable at the out-of-network level.

Non-emergency services provided in the emergency room are not covered by Aetna Managed Choice unless you are referred by your PCP.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on Aetna Managed Choice's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Charges not covered

A network provider contracts with Aetna Managed Choice to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under the Aetna Managed Choice plan or not approved by the Aetna Managed Choice plan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the POS plan and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see [Claims and appeals for Aetna medical plans](#).

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under the Aetna Managed Choice plan. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see [Claims and appeals for Aetna medical plans](#).

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible (\$500 individual/\$1,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the \$500 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the \$1,000 family deductible, but no one person can apply more than the individual deductible (\$500) toward the family deductible amount.

Once you have met the deductible, Aetna Managed Choice normally pays 70% of reasonable and customary (R&C) charges for covered expenses that are received out-of-network.

Out-of-pocket maximum

The individual out-of-pocket maximum for services rendered outside of the network is \$3,000 (\$6,000 family maximum). This amount includes the \$500 individual (\$1,000 family) deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed reasonable and customary (R&C) expenses, penalties, any coinsurance charges for mental health/chemical dependency services, or services not covered under Aetna Managed Choice. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of R&C for the remainder of the calendar year.

Eligible 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 (\$3,000) to the family out-of-pocket maximum (\$6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed R&C;
- Pharmacy expenses;
- Any coinsurance charges for mental health/chemical dependency services;
- Charges for services not covered under the POS plan; and
- Any expense that would have been reimbursed if you had notified Aetna Managed Choice or precertified the care.

In addition, expenses incurred when using network services do not count toward your out-of-network, out-of-pocket maximum.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at 70% of R&C for covered services, subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines; adult exams are limited to \$250 annually. For frequency guidelines, call Aetna.
- **Routine health screenings** (based on AMA guidelines):
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy as part of a routine physical; and
 - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men ages 50 and older.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

Aetna Managed Choice covers only the diagnosis and treatment of underlying causes of infertility. Medical infertility coverage is not offered; however, coverage for infertility prescription drugs is provided through the **Prescription drug program**, up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500. These limits are in addition to any other prescription drug limits or requirements.

For more specific information, contact Aetna directly.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of R&C, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Precertification is required for hospitalization and certain outpatient procedures. For more information, see **Precertification/notification**.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact Aetna within 48 hours. If you are unable to do this, have a family member contact Aetna.

If you (or your family member) fail to contact Aetna, you will pay a \$500 penalty. In addition, your hospitalization will not be covered at the network level of reimbursement. See

Precertification/notification.

Non-emergency services provided in an emergency room are not covered.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on Aetna's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Mental health/chemical dependency

Aetna Managed Choice provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call Aetna at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call Aetna before seeking treatment for mental health or chemical dependency treatment. A directory of participating providers is available directly from Aetna at 1-800-545-5862 or online at **www.aetna.com**.

Action	Inpatient	Outpatient
If you call Aetna and use its network provider/facility	No deductible, eligible expenses covered at 100% of the negotiated rate; maximum benefit of 30 days per calendar year*	No deductible, \$25 copayment per visit; maximum benefit of 52 visits per calendar year*
If you call Aetna but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you do not call and do not use Aetna's network provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under Aetna Managed Choice. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under Aetna Managed Choice.

Mental health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

No benefit will be paid for services that are not considered to be medically necessary. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You must call Aetna to precertify inpatient services or a \$500 penalty may apply in each occurrence. You do not need a referral from your PCP for any mental health/chemical dependency care you may require that is precertified through Aetna. If you do not use the recommended provider, you will be reimbursed at 70% of R&C after the deductible is met.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. There is a maximum benefit of 30 days per calendar year for inpatient mental health/chemical dependency services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by Aetna in advance of the admission.

Outpatient services

You are encouraged to call Aetna for outpatient referrals. If you call and use the recommended provider, you will make a \$25 copayment for each visit. If you do not use the recommended provider, you will be reimbursed at 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

When emergency care is required for mental health treatment, you (or your representative or physician) must call Aetna within 48 hours after the emergency care is given. Aetna's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you must get a referral from Aetna for any additional services. Without a referral as required, benefits will be reduced. All benefits, as long as they are deemed medically necessary by Aetna, are payable as shown in the highlights chart.

Medically necessary

Aetna Managed Choice will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. Aetna Managed Choice will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless Aetna Managed Choice determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about what Aetna Managed Choice covers, see **Covered services and supplies**. You may also contact Aetna Managed Choice directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Remember that you and your family members always have the choice of what kind of medical care to get, as well as which provider to use and where to receive care — regardless of what Aetna Managed Choice covers.

Retrospective Record Review

If you are enrolled in the Aetna Managed Choice Plan, your claims and medical records may be subject to retrospective review. The purpose of retrospective review is to analyze potential quality and utilization issues after services have been provided, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to members includes the retrospective review of claims submitted for payment and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Aetna Managed Choice Plan requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent Review.** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge Planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

CIGNA POS

Type of service	Network	Out-of-network
Annual deductible		
▪ Individual	▪ None	▪ \$500
▪ Maximum per family	▪ None	▪ \$1,000
Annual out-of-pocket maximum (includes deductible)		
▪ Individual	▪ None	▪ \$3,000
▪ Maximum per family	▪ None	▪ \$6,000
Lifetime maximum	▪ None	▪ None
Professional care (in office)		
▪ PCP visits	▪ \$15 copayment	▪ 70% of R&C after deductible
▪ Specialist visits	▪ \$25 copayment	▪ 70% of R&C after deductible
▪ Allergy treatment	▪ 100% after copayment; no copayment if office visit fee is not charged	▪ 70% of R&C after deductible
Routine care (subject to frequency limits)		
▪ Well adult	▪ 100% after copayment	▪ 70% of R&C, no deductible, up to \$250 annually
▪ Well-child and immunizations	▪ 100% after copayment	▪ 70% of R&C, no deductible
▪ Routine vision exams	▪ 100% after copayment, limited to one exam every 24 months	▪ Not covered
▪ Routine hearing exams	▪ Not covered	▪ Not covered
Hospital inpatient and outpatient		
▪ Semi-private room and board, doctor's charges, lab, x-ray, and surgical care	▪ 100%	▪ 70% of R&C after deductible; precertification required for hospitalization and certain outpatient procedures

Type of service	Network	Out-of-network
Maternity care		
<ul style="list-style-type: none"> Physician office visit 	<ul style="list-style-type: none"> 100% (copayment applies for initial prenatal visit) 	<ul style="list-style-type: none"> 70% of R&C after deductible
<ul style="list-style-type: none"> Hospital delivery 	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Emergency care (no coverage if not a true emergency)		
<ul style="list-style-type: none"> Hospital emergency room 	<ul style="list-style-type: none"> \$50 copayment, waived if admitted for any reason within 24 hours 	<ul style="list-style-type: none"> \$50 copayment, waived if admitted for any reason within 24 hours
<ul style="list-style-type: none"> Urgent care facility 	<ul style="list-style-type: none"> \$15 copayment 	<ul style="list-style-type: none"> \$15 copayment
Outpatient lab and x-ray services	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Outpatient short-term rehabilitation		
<ul style="list-style-type: none"> Physical, speech, or occupational therapy 	<ul style="list-style-type: none"> \$25 copayment per office visit, up to 60 visits per year for all types of therapy 	<ul style="list-style-type: none"> 70% of R&C after deductible, up to 60 visits per year for all types of therapy
<ul style="list-style-type: none"> Chiropractic therapy 	<ul style="list-style-type: none"> \$25 copayment per visit, up to 20 visits per year 	<ul style="list-style-type: none"> 70% of R&C after deductible, up to 20 visits per year
Durable medical equipment (includes orthotics/prosthetics and appliances)	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Home health care	<ul style="list-style-type: none"> 100%, limited to 40 visits annually for network and out-of-network services combined 	<ul style="list-style-type: none"> 70% of R&C after deductible, limited to 40 visits annually for network and out-of-network services combined
Hospice	<ul style="list-style-type: none"> 100% 	<ul style="list-style-type: none"> 70% of R&C after deductible
Skilled nursing facility	<ul style="list-style-type: none"> 100% (limited to 120 days annually for network and out-of-network services combined) 	<ul style="list-style-type: none"> 70% of R&C after deductible (limited to 120 days for network and out-of-network services combined)
Infertility treatment	<ul style="list-style-type: none"> Prescriptions covered up to a \$2,500 annual pharmacy maximum with a lifetime maximum of \$7,500 (covered through the Prescription drug program) Contact CIGNA POS for specific coverage. 	
Prescription drugs (refer to <u>Prescription drug program</u>)		
Mental health and chemical dependency (refer to <u>Mental health and chemical dependency</u>)		

This chart is intended as a brief summary of benefits. Not all covered services, exclusions and limitations are shown. For additional information and/or clarification of benefits, see **Covered services and supplies** and **Exclusions and limitations**.

Network coverage

To receive the highest level of benefits from CIGNA POS, referred to as the network level of benefits, you must receive care from your primary care physician (PCP) or have a referral from your PCP to obtain additional care within the network.

Primary care physician (PCP)

Your primary care physician (PCP) is the coordinator of your and your covered dependent's medical care, excluding treatment provided through the **mental health and chemical dependency** program. Your copayment will be \$15 for each PCP office visit.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in CIGNA POS is available directly from CIGNA POS at 1-800-794-4953 or online at www.cigna.com/general/misc/docdir.html.

Specialists

If you need the services of a specialist, your PCP will refer you to a network specialist for treatment. The copayment for a specialist's office visit is \$25. Further treatment from the specialist will be coordinated through your PCP.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment. If you receive an allergy injection only (without a physician office visit charge), you will not be required to pay a copayment. If services are for other than an allergy injection, the specialist copayment of \$25 will apply. If services are obtained from your PCP and you are charged for an office visit, the primary care physician copayment of \$15 will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% for covered services after the applicable copayment.

Routine care

The CIGNA POS plan offers preventive care services and health screenings to help detect health problems early. The following are covered at 100% for covered services after a copayment for each doctor's office visit. Care must be provided or referred by your PCP, except where noted below.

- **Routine physical exam:** well-child care and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines or as directed by the PCP. For frequency guidelines, call CIGNA.
- **Routine health screenings:**
 - Gynecological exam including a Pap smear performed by a network provider annually. A referral from your PCP is not required. Any follow-up or related care also may be provided directly by your network gynecologist;
 - Mammogram with no copayment, unless there is an associated doctor's office visit, at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy

- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older;
- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist; no PCP referral required.

Infertility

The CIGNA POS plan covers only the diagnosis and treatment of underlying causes of infertility. Medical infertility coverage is not offered; however, coverage for infertility prescription drugs is provided through the **Prescription drug program**, up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500. These limits are in addition to any other prescription drug limits or requirements.

For more specific information, contact CIGNA directly.

Hospital

Hospital care (inpatient and outpatient) coordinated through your PCP or network specialist is covered at 100% for covered services. If you use a network provider but are *not* referred by your PCP or by a network physician, you will be reimbursed at the out-of-network level based on the negotiated rate contracted with the Claims Administrator. Services provided by a network physician in an out-of-network hospital will be reimbursed at the out-of-network level.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital within 24 hours for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

Emergency care does not require a referral from your PCP before services are rendered, as long as your visit is a true emergency as defined by the CIGNA POS plan.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact the PCP or a \$500 penalty may apply. See **Precertification/notification**.

When emergency care has ended, you must get a referral from your PCP before receiving any additional services. If you or your dependent does not get a referral as required, benefits are payable at the out-of-network level.

Non-emergency services provided in the emergency room are not covered by the CIGNA POS plan unless you are referred by your PCP.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on CIGNA's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Charges not covered

A network provider contracts with the CIGNA POS plan to participate in the network. Under the terms of this contract, a network provider may not charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate for covered services.

You may agree with the network provider to pay any charges for services or supplies not covered under the CIGNA POS plan or not approved by the CIGNA POS plan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the CIGNA POS plan and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see the **Claims and appeals for CIGNA medical plans** section.

Out-of-network coverage

You can use an out-of-network provider for medical services and still receive reimbursement under the CIGNA POS plan. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible.

For information about how to file a claim for out-of-network services or appeal a denied claim, see the **Claims and appeals for CIGNA medical plans** section.

Deductible and coinsurance

If you elect to use physicians or other providers outside the network, you will need to satisfy an annual deductible (\$500 individual/\$1,000 family) before any benefit will be paid. Once you meet your deductible, you must submit a claim form accompanied by your itemized bill to be reimbursed for covered expenses.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible represents the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible can be applied toward the family deductible. The family deductible can be met as follows:

- **Two in a family:** Each member must meet the \$500 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the \$1,000 family deductible, but no one person can apply more than the individual deductible (\$500) toward the family deductible amount.

Once you have met the deductible, the CIGNA POS plan normally pays 70% of reasonable and customary (R&C) charges for covered expenses that are received out-of-network.

Out-of-pocket maximum

The individual out-of-pocket maximum for services rendered outside of the network is \$3,000 (\$6,000 family maximum). This amount includes the \$500 individual (\$1,000 family) deductible and represents the most you will have to pay out of your own pocket in a calendar year for services received outside the network, excluding charges that exceed reasonable and customary (R&C) expenses, penalties, any coinsurance charges for mental health/chemical dependency services, or services not covered under the CIGNA POS plan. Once this out-of-pocket maximum is met, covered expenses are payable at 100% of R&C for the remainder of the calendar year.

Eligible 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 (\$3,000) to the family out-of-pocket maximum (\$6,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are:

- Expenses that exceed R&C;
- Pharmacy expenses;
- Any coinsurance charges for mental health/chemical dependency services;

- Charges for services not covered under the POS plan; and
- Any expense that would have been reimbursed if you had precertified the care.

In addition, expenses incurred when using network services do not count toward your out-of-network, out-of-pocket maximum.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at 70% of R&C for covered services, subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines; adult exams are limited to \$250 annually. For frequency guidelines, call CIGNA.
- **Routine health screenings** (based on AMA guidelines):
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy as part of a routine physical (precertification required); and
 - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men ages 50 and older.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

The CIGNA POS plan covers only the diagnosis and treatment of underlying causes of infertility. Medical infertility coverage is not offered; however, coverage for infertility prescription drugs is provided through the **Prescription drug program**, up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500. These limits are in addition to any other prescription drug limits or requirements.

For more specific information, contact CIGNA directly.

Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 70% of R&C, after you meet your annual deductible. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available). Precertification is required for hospitalization and certain outpatient procedures. For more information, see **Precertification/notification**.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital within 24 hours for any condition, the copayment is waived.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact CIGNA POS within 48 hours. If you are unable to do this, have a family member contact CIGNA POS.

If you (or your family member) fail to contact CIGNA POS, you will pay a \$500 penalty. In addition, your hospitalization will not be covered at the network level of reimbursement. See

Precertification/notification.

Non-emergency services provided in an emergency room are not covered.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and generally do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on CIGNA's Web site. You do not need a referral or any prior authorization to use an urgent care center. Services provided by an urgent care center are covered at 100% for covered services after a \$15 copayment.

Mental health/chemical dependency

The CIGNA POS plan provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call CIGNA at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call CIGNA before seeking treatment for mental health or chemical dependency treatment. A directory of participating providers is available directly from CIGNA at 1-800-794-4953 or online at www.cigna.com/general/misc/docdir.html.

Action	Inpatient	Outpatient
If you call CIGNA and use its network provider/facility	No deductible, eligible expenses covered at 100% of the negotiated rate*	No deductible, \$25 copayment per visit; maximum benefit of 52 visits per calendar year*
If you call CIGNA but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you do not call and do not use CIGNA's network provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 70% of R&C*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you call the CIGNA POS Plan but do not use CIGNA POS Plan's network provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 70% of R&C*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Mental health and chemical dependency treatment benefits are subject to the same medical necessity requirements, coverage limitations and deductibles that are required under CIGNA POS. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under the CIGNA POS plan.

Mental health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

No benefit will be paid for services that are not considered to be medically necessary. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You must call CIGNA to precertify inpatient services or a \$500 penalty may apply in each occurrence. You do not need a referral from your PCP for any mental health/chemical dependency care you may require that is precertified through CIGNA. If you do not use the recommended provider, you will be reimbursed at 70% of R&C after the deductible is met.

In general, inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by CIGNA in advance of the admission.

Outpatient services

You are encouraged to call CIGNA for outpatient referrals. If you call and use the recommended provider, you will make a \$25 copayment for each visit. If you do not use the recommended provider, you will be reimbursed at 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

When emergency care is required for mental health treatment, you (or your representative or physician) must call CIGNA within 48 hours after the emergency care is given. CIGNA's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you must get a referral from CIGNA for any additional services. Without a referral as required, benefits will be reduced. All benefits, as long as they are deemed medically necessary by CIGNA, are payable as shown in the highlights chart.

Medically necessary

The CIGNA POS plan will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. The CIGNA POS plan will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless the CIGNA POS plan determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about what the CIGNA POS plan covers, see **Covered services and supplies**. You may also contact the CIGNA POS plan directly to confirm coverage of a particular service or supply and to find out what limits may apply.

Remember that you and your family members always have the choice of what kind of medical care to get, as well as which provider to use and where to receive care — regardless of what the CIGNA POS plan covers.

Health Plan 2000 (UnitedHealthcare)

Health Plan 2000 (High Deductible Medical Plan option) is available in all locations. It is for employees who generally have few medical expenses or are willing to fund a large part of the cost of coverage before benefits are paid.

Health Plan 2000 is administered by UnitedHealthcare. You can save money by using UnitedHealthcare's preferred providers. When you use a preferred provider, reimbursement is based on a contracted rate rather than the reasonable and customary (R&C) amounts.

Type of service	Health Plan 2000 (UnitedHealthcare)
Annual deductible	
▪ Individual	▪ \$2,000
▪ Maximum per family	▪ \$4,000
Annual out-of-pocket maximum (includes deductible)	
▪ Individual	▪ \$5,000
▪ Maximum per family	▪ \$10,000
Lifetime maximum	▪ None
Professional care (in office)	
▪ PCP or specialist visits	▪ 80% of negotiated rate after deductible for preferred providers; 70% of R&C after deductible for non-preferred providers
Routine care (subject to frequency limits)	
▪ Routine physical exam	▪ 100% of negotiated rate for preferred providers; 100% of R&C for non-preferred providers; no deductible; up to \$250 annually
▪ Well-child and immunizations	▪ 100% of negotiated rate for preferred providers; 100% of R&C for non-preferred providers; no deductible
▪ Routine well-woman exam	▪ 100% of negotiated rate for preferred providers; 100% of R&C for non-preferred providers; no deductible
▪ Routine vision exam	▪ 100% of negotiated rate for preferred providers; 100% of R&C for non-preferred providers; no deductible; limit 1 exam per 24 months
▪ Routine hearing exam	▪ Not covered unless part of routine physical
Hospital inpatient and outpatient	
▪ Semiprivate room and board, doctor's charges, lab, x-ray, and surgical care	▪ 80% of negotiated rate after deductible when using preferred providers; 70% of R&C after deductible when using non-preferred providers; notification required for hospitalization, facility admissions and certain outpatient procedures and services
Emergency care	▪ 80% of covered services after deductible
Urgent care center	▪ 80% of negotiated rate after deductible when using preferred providers; 70% of R&C after deductible when using non-preferred providers

Type of service	Health Plan 2000 (UnitedHealthcare)
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Prescription drugs (refer to Prescription drug program)

Mental health and chemical dependency (refer to Mental health/chemical dependency)

This chart is intended as a brief summary of benefits. Not all covered services, exclusions and limitations are shown. For additional information and/or clarification of benefits, see Covered services and supplies and Exclusions and limitations.

How the Plan works

This section contains more detailed information about Health Plan 2000's provisions and how this medical plan option works.

You have a choice of using preferred providers or non-preferred providers. Using preferred providers saves you money in two ways. First, preferred providers charge special, negotiated rates, which are generally lower than the R&C amounts. Second, the level of reimbursement for many services is higher when you use a preferred provider.

A directory of preferred providers is available directly from UnitedHealthcare by calling 1-877-311-7845 or by visiting the Web site at www.provider.uhc.com/citigroup.

Deductible and coinsurance

You must meet an annual individual deductible of \$2,000 (\$4,000 family maximum) before Health Plan 2000 pays any benefits, unless the service is covered at 100%, such as routine preventive care.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible is the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible count toward the family deductible. The family deductible can be met as follows:

- **Up to two in a family:** Each member must meet the \$2,000 individual deductible; or
- **Three or more in a family:** Expenses can be combined to meet the \$4,000 family deductible, but no one person can apply more than the \$2,000 individual deductible toward the family deductible amount.

Once you have satisfied the deductible, Health Plan 2000 normally pays 80% of the negotiated rate for covered health services if you or your covered dependent uses a UnitedHealthcare preferred hospital/provider. Expenses are normally reimbursed at 70% of R&C for claims for covered services submitted for a non-preferred provider.

Out-of-pocket maximum

Your individual out-of-pocket maximum is \$5,000 (\$10,000 family maximum). The amount includes the \$2,000 individual (\$4,000 family) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Eligible expenses 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 (\$5,000) to the family out-of-pocket maximum (\$10,000).

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate or of R&C for the remainder of the calendar year.

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed R&C, pharmacy copayments, any coinsurance charges for mental health/chemical dependency services, charges for services not covered under the plan, and any expense that would have been reimbursed if you had precertified the care.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at:

- 100% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); and
- 100% of the reasonable and customary charges (for care received by a non-preferred provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines; adult exams are limited to \$250 annually. For covered exams and frequency guidelines, call UnitedHealthcare at 1-877-311-7845;
- Routine health screenings:
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy (covered as part of a routine physical); and
 - Prostatic-specific antigen (PSA) screening.
- **Routine vision exam:** limited to one exam per 24 months
- **Routine hearing exam:** covered only as part of routine physical.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

Health Plan 2000 covers medical and pharmacy expenses associated with infertility treatment, subject to the following limits:

- Medical expenses up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000; and
- Prescription drug expenses associated with infertility treatment up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

Note: Coverage for prescription drugs used to treat infertility is provided through the **Prescription drug program**. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all UnitedHealthcare plans combined.

In order to be eligible for infertility benefits, you or your eligible dependent must have a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

For more specific information, contact UnitedHealthcare directly.

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); or
- 70% of R&C (for care received from a non-preferred provider in an area where one was available.)

Notification is required for hospitalization, facility admissions, and certain outpatient procedures and services. For more information, see [**Precertification/notification**](#).

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); or
- 80% of R&C (for care received from a non-preferred provider).

Non-emergency services provided in an emergency room are not covered.

See the [**Glossary**](#) for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact UnitedHealthcare within 48 hours. If you are not able to do this, have a family member contact UnitedHealthcare or a \$500 penalty may apply. See [**Precertification/notification**](#).

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). Urgent care centers will be reimbursed at:

- 80% of the negotiated rate (after deductible is met) for care received from a UnitedHealthcare preferred provider; or
- 70% of R&C (after deductible is met) for care received from a non-preferred provider.

For more information about how to file a claim or appeal a denied claim, see the [**About Your Health Care Benefits**](#) section.

Mental health/chemical dependency

Health Plan 2000 provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call UnitedHealthcare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call UnitedHealthcare before seeking treatment for mental health or chemical dependency treatment.

A directory of participating providers is available directly from UnitedHealthcare at 1-877-311-7845 or online at www.provider.uhc.com/citigroup.

Action	Inpatient	Outpatient
If you call UnitedHealthcare and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate; maximum of 30 days per calendar year*	No deductible; \$25 copayment per visit; maximum benefit of 52 visits per calendar year*
If you call UnitedHealthcare but do not use its network provider/facility	After the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you do not call and do not use UnitedHealthcare's provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 70% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Unlike the medical benefits under Health Plan 2000, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage guidelines and deductibles that are required under Health Plan 2000. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required under Health Plan 2000.

Mental health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

No benefit will be paid for services that are not considered to be medically necessary. Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You *must* call UnitedHealthcare to give notification of inpatient services or a \$500 penalty may apply to each occurrence.

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. After you meet your deductible, inpatient stays are covered at 80% when you use UnitedHealthcare's network provider or 70% of R&C if you use an out-of-network provider. There is a maximum benefit of 30 days per calendar year for mental health/chemical dependency inpatient services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by UnitedHealthcare in advance of the admission.

Outpatient services

You are encouraged to call UnitedHealthcare for outpatient referrals, although a referral is not required. If you call UnitedHealthcare and use a network provider, you will pay a \$25 copayment for each visit. If you use an out-of-network provider, you will be reimbursed at 50% of R&C for covered services after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call UnitedHealthcare within 48 hours after the emergency care is given. UnitedHealthcare's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you should call UnitedHealthcare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights chart.

No medical necessity (except for mental health/chemical dependency benefits)

Health Plan 2000 provides coverage based on the benefits described in this summary plan description. There is no determination of medical necessity.

Medically necessary — mental health/chemical dependency benefits

UnitedHealthcare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. UnitedHealthcare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless UnitedHealthcare's behavioral health provider determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about what Health Plan 2000 covers, see **Covered services and supplies** or call UnitedHealthcare at 1-877-311-7845 to confirm coverage of a particular service or supply and to find out what limits may apply.

Out-of-Area Plan (UnitedHealthcare)

The Out-of-Area (OOA) plan option is available *only* if you live in an area where no POS plan option is available. The OOA plan option is administered by UnitedHealthcare.

Type of service	Out-of-Area plan option (<i>UnitedHealthcare — available only if you live in an area where a POS plan is not available</i>)
Annual deductible	
▪ Individual	▪ \$300
▪ Maximum per family	▪ \$600
Annual out-of-pocket maximum (includes deductible)	
▪ Individual	▪ \$1,000
▪ Maximum per family	▪ \$2,000
Lifetime maximum	▪ None
Professional care (in office)	
▪ PCP or specialist visits	▪ 80% after deductible
Routine care (subject to frequency limits)	
▪ Routine physical exam	▪ 100%, no deductible; up to \$250 annually
▪ Well-child and immunizations	▪ 100%, no deductible
▪ Routine well-woman exam	▪ 100%, no deductible
▪ Routine vision exam	▪ 100%, no deductible; limit 1 exam per 24 months
▪ Routine hearing exam	▪ 100%, no deductible; limit 1 exam per 24 months
Hospital inpatient and outpatient	
▪ Semiprivate room and board, doctor's charges, lab, x-ray, and surgical care	▪ 80% after deductible; notification required for hospitalization, facility admissions, and certain outpatient procedures and services
Emergency care	
▪ No coverage if not a true emergency	▪ 80% after deductible
Urgent care center	▪ 80% after deductible
Prescription drugs (refer to <u>Prescription drug program</u>)	
Mental health and chemical dependency (refer to <u>Mental health/chemical dependency</u>)	

This chart is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see **Covered services and supplies** and **Exclusions and limitations** or call UnitedHealthcare.

How the Plan works

This section contains more detailed information about the Out-of-Area plan option provisions and how the option works.

For information about how to file a claim or appeal a denied claim, see [Claims and appeals for UnitedHealthcare plans](#).

Deductible and coinsurance

You must meet an annual individual deductible of \$300 (\$600 family maximum) before the OOA plan option pays any benefits.

The individual deductible applies to all covered expenses except routine preventive care and must be met each calendar year before any benefits will be paid.

The family deductible is the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible count toward the family deductible. The family deductible can be met as follows:

- **Up to two in a family:** each member must meet the \$300 individual deductible; or
- **Three or more in a family:** expenses can be combined to meet the \$600 family deductible, but no one person can apply more than the \$300 individual deductible toward the family deductible amount.

Once you have satisfied the deductible, the OOA plan normally pays 80% of the negotiated rate for covered services if you or your covered dependent uses a UnitedHealthcare preferred hospital/provider or 80% of R&C for claims submitted for a non-preferred provider for covered health services.

Out-of-pocket maximum

Your individual out-of-pocket maximum is \$1,000 (\$2,000 family maximum). The amount includes the \$300 individual (\$600 family) deductible. This represents the most you will have to pay out of your own pocket in a calendar year.

Eligible expenses can be combined to meet the family out-of-pocket maximum, but no one person can apply more than the individual out-of-pocket amount (\$1,000) to the family out-of-pocket maximum (\$2,000).

Once the out-of-pocket maximum is reached, covered expenses are payable at 100% of the negotiated rate for a preferred provider or R&C for a non-preferred provider for the remainder of the calendar year.

Not all expenses count toward your out-of-pocket maximum. Among those that do not count are expenses that exceed R&C, pharmacy copayments, any coinsurance charges for mental health and chemical dependency treatment, charges for services not covered under the plan, penalties, and any expense that would have been reimbursed if you had notified UnitedHealthcare in advance.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at:

- 100% of the negotiated rate for covered service (for care received from a UnitedHealthcare preferred provider); and
- 100% of the R&C (for care received from a non-preferred provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines; adult exams are limited to \$250 annually. For covered exams and frequency guidelines, call UnitedHealthcare at 1-877-311-7845.
- Routine health screenings:
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons aged 50 and older;
 - Colonoscopy (covered as part of a routine physical); and
 - Prostatic-specific antigen (PSA) screening;
- **Routine vision exam:** limited to one exam per 24 months
- **Routine hearing exam:** limited to one exam per 24 months.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

The OOA plan covers medical *and* pharmacy expenses associated with infertility treatment, subject to the following limits:

- Medical expenses up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000; and
- Prescription drug expenses associated with infertility treatment up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

Note: Coverage for prescription drugs used to treat infertility is provided through the **Prescription drug program**. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all UnitedHealthcare plans combined.

In order to be eligible for infertility benefits, you or your eligible dependent must have a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

For more specific information, contact UnitedHealthcare directly.

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); or
- 80% of R&C (for care received from a non-preferred provider).

Notification is required for hospitalization, facility admissions, and certain outpatient procedures and services. For more information, see **Precertification/notification**.

Emergency care

After you meet your annual deductible, emergency care will be reimbursed at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); or
- 80% of R&C (for care received from non-preferred provider).

Non-emergency services provided in an emergency room are not covered under the OOA plan.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact UnitedHealthcare within 48 hours. If you are not able to do this, have a family member contact UnitedHealthcare or a \$500 penalty may apply. See **Precertification/notification**.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). Covered expenses incurred at an urgent care center will be reimbursed at:

- 80% of the negotiated rate (after deductible) for care received from a UnitedHealthcare preferred provider; and
- 80% of R&C (after deductible) for care received from a non-preferred provider.

Mental health/chemical dependency

The OOA plan provides access to confidential mental health and chemical dependency treatment through a network of participating counselors and specialized practitioners.

When you call UnitedHealthcare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right care provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call UnitedHealthcare before seeking treatment for mental health or chemical dependency treatment.

A directory of participating providers is available directly from UnitedHealthcare at 1-877-311-7845 or online at **www.provider.uhc.com/citigroup**.

Action	Inpatient	Outpatient
If you call UnitedHealthcare and use its provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of the negotiated rate; maximum benefit of 52 days per calendar year*
If you call UnitedHealthcare but do not use its provider/facility	After the deductible, eligible expenses covered at 80% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar Year*
If you do not call and do not use UnitedHealthcare's provider/facility	\$500 penalty per occurrence; after the deductible, eligible expenses covered at 80% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Unlike the medical benefits under the Out-of-Area plan, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage guidelines and deductibles that are required under the medical portion of the plan. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required under the medical portion of the plan.

Mental health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

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

Mental health and chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You *must* call UnitedHealthcare to give notification of inpatient services or a \$500 penalty may apply in each occurrence.

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. There is a maximum benefit of 30 days per calendar year for inpatient services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by UnitedHealthcare in advance of the admission.

Outpatient Services

You are encouraged to call UnitedHealthcare for outpatient referrals, although a referral is not required. If you call UnitedHealthcare and use its providers, you will be reimbursed at 50% of the negotiated rate after the deductible is met. If you do not use UnitedHealthcare's recommended providers, you will be reimbursed at 50% of R&C, after the deductible is met. There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

Emergency care does not require a referral from UnitedHealthcare. When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call UnitedHealthcare within 48 hours after the emergency care is given. UnitedHealthcare's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you should call UnitedHealthcare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights chart.

No medical necessity (except for mental health/chemical dependency benefits)

The Out-of-Area plan provides coverage based on the benefits described in this summary plan description. There is no determination of medical necessity.

Medically necessary — mental health/chemical dependency benefits

UnitedHealthcare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. UnitedHealthcare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless UnitedHealthcare's behavioral health provider determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about coverage for a particular service or supply or limits that may apply, see **Covered services and supplies** or call UnitedHealthcare at 1-877-311-7845.

Health Maintenance Organization(s)

Citigroup has entered into an arrangement with UnitedHealthcare, Aetna, and CIGNA HealthCare to provide self-funded Health Maintenance Organization (HMO) plans. In addition to the above self-funded HMOs, Citigroup has entered into numerous fully insured arrangements with other HMOs. Plan descriptions for these fully-insured HMOs differ and can be obtained directly from the HMO, at no cost to you.

Your home zip code determines if you are eligible to participate in one of the HMOs offered by Citigroup.

HMO coverage differs from the other Citigroup medical options in two important ways:

- HMOs emphasize preventive care. In addition to comprehensive hospital and surgical coverage, HMOs offer physical examinations, routine office visits and other services. Their concept, as their name suggests, is “health maintenance.”
- Each HMO has contracted physicians and is affiliated with certain hospitals. In most HMOs, you **must** use these HMO resources exclusively — except in an emergency. The HMO must be notified of the emergency within 48 hours.

It is important to understand that Citigroup is offering only the opportunity to join an HMO. The actual coverage provided by the HMO is the HMO’s responsibility. Citigroup does not guarantee or have any responsibility for the quality of health care or service provided or arranged for by the HMO. Citigroup is not responsible for medical bills that are not covered services under the HMO. HMO participants have the right to choose their own health care professionals and the services they receive under the HMO.

It is important to check directly with the HMO prior to enrolling to ensure that you fully understand the provisions of the plan. All benefits, limitations and exclusions for the HMOs are listed in their member brochures and contracts. At your request, the HMO will supply you with written materials concerning:

- The nature of services provided to members;
- Conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility to participate in the plan) and circumstances under which services may be denied; and
- The procedures to be followed when obtaining services, and the procedures available for the review of claims for services which are denied in whole or in part.

The following sections describe the features of the HMO plans provided by UnitedHealthcare, Aetna, and CIGNA HealthCare (collectively the Health Plans) in which Citigroup funds all benefits becoming due under the Health Plans. All other HMOs offered by Citigroup have different coverage limits that are not explained in this summary.

UnitedHealthcare EPO

UnitedHealthcare refers to its HMO as an Exclusive Provider Organization (EPO).

Type of service	
Annual deductible	▪ None
Maximums	
▪ Annual maximum copayment per employee	▪ None
▪ Annual maximum copayment per family	▪ None
▪ Individual lifetime maximum benefits	▪ Unlimited
Office care	
▪ PCP visit copayment	▪ \$15 copayment per visit
▪ Specialist visit copayment	▪ \$25 copayment per visit
▪ Outpatient surgery in physician's office	▪ Copayment applies if office visit is charged
Allergy treatment	
▪ Allergy testing	▪ \$15 (PCP) or \$25 (specialist) copayment per visit
▪ Allergy injections	▪ 100% coverage
▪ Allergy serum	▪ 100%
Preventive care	
▪ Well-child care and immunizations	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine physical exam	▪ \$15 copayment per visit (subject to frequency limits)
▪ Adult immunizations	▪ \$15 (PCP) copayment per visit
▪ Routine GYN exam/well-woman care	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine eye exam/routine hearing exam	▪ \$15 (PCP) copayment per visit (limited to one eye exam and hearing exam every 24 months)
Lab and x-ray	
▪ Hospital inpatient and outpatient	▪ 100%
▪ X-ray/lab outpatient facility	▪ 100%
Hospital care and services	
▪ Inpatient surgery	▪ 100%
▪ Outpatient surgery	▪ 100%
Emergency care	
▪ Hospital emergency room	▪ \$50 copayment (waived if admitted)
▪ Ambulance	▪ 100%
▪ Urgent care facility	▪ \$15 copayment per visit
Maternity care	
▪ Inpatient hospital delivery	▪ 100%
▪ Office visits (prenatal)	▪ \$25 copayment (first visit only)
▪ Office visits (postnatal)	▪ 100%

Type of service

Other medical services

<ul style="list-style-type: none"> ▪ Outpatient therapy (includes speech therapy, physical therapy, and occupational therapy to improve patient's condition) 	<ul style="list-style-type: none"> ▪ \$25 copayment per visit (subject to annual maximum)
<ul style="list-style-type: none"> ▪ Chiropractic care 	<ul style="list-style-type: none"> ▪ \$25 copayment per visit (subject to annual maximum)
<ul style="list-style-type: none"> ▪ Skilled nursing facility 	<ul style="list-style-type: none"> ▪ 100%, up to a 60-day annual maximum
<ul style="list-style-type: none"> ▪ Home health care 	<ul style="list-style-type: none"> ▪ 100%, up to a 120-visit maximum
<ul style="list-style-type: none"> ▪ Hospice care 	<ul style="list-style-type: none"> ▪ 100% (limited to 180 days per lifetime)
<ul style="list-style-type: none"> ▪ Durable medical equipment (orthotics/prosthetics and appliances) 	<ul style="list-style-type: none"> ▪ 100% (notification required for equipment over \$1,000)
<ul style="list-style-type: none"> ▪ Disposable medical supplies 	<ul style="list-style-type: none"> ▪ 100%

Infertility treatment

<ul style="list-style-type: none"> ▪ Diagnosis and treatment of underlying condition 	<ul style="list-style-type: none"> ▪ \$25 copayment per visit
<ul style="list-style-type: none"> ▪ In vitro fertilization, artificial insemination, and other procedures or treatment to facilitate a pregnancy 	<ul style="list-style-type: none"> ▪ Not covered

Prescription drugs

<ul style="list-style-type: none"> ▪ Retail (up to 34-day supply) <ul style="list-style-type: none"> ▪ Generic ▪ Preferred brand (brand-name formulary) ▪ Non-preferred brand 	<ul style="list-style-type: none"> ▪ \$10 copayment ▪ \$20 copayment ▪ \$40 copayment
<ul style="list-style-type: none"> ▪ Mail-order (up to 90-day supply) <ul style="list-style-type: none"> ▪ Generic ▪ Preferred brand (brand-name formulary) ▪ Non-preferred brand 	<ul style="list-style-type: none"> ▪ \$20 copayment ▪ \$40 copayment ▪ \$80 copayment

Mental health and chemical dependency

<ul style="list-style-type: none"> ▪ Inpatient 	<ul style="list-style-type: none"> ▪ 100% coverage, 30-day annual maximum*
<ul style="list-style-type: none"> ▪ Outpatient 	<ul style="list-style-type: none"> ▪ \$25 copayment, 52-visit annual maximum*

* Combined limits for mental health and chemical dependency benefits.

How the UnitedHealthcare EPO Plan works

Plan participants have access to a network of participating primary care physicians, specialists, and hospitals that meet UnitedHealthcare's strict requirements for quality and service. These providers are independent physicians and facilities that are closely monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards, and ongoing training.

Each participant in the UnitedHealthcare EPO must select a primary care physician (PCP) when he or she enrolls. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

Primary care physician (PCP)

As a participant in the UnitedHealthcare EPO, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when necessary, your PCP will refer you to other doctors or facilities for treatment. Your copayment will be \$15 for each PCP office visit.

However, you do not need to obtain a referral from your PCP to receive the network level of benefits when you receive care from any network provider in the UnitedHealthcare EPO.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in your HMO Plan is available directly from UnitedHealthcare at 1-877-311-7845 or online at www.myuhc.com. If you do not choose a PCP, one will be selected for you.

Specialists

Your PCP may recommend that you see a specialist or other facility for treatment or for covered preventive care services. You do not need to obtain a referral from your PCP to receive the network level of benefits when you receive care from any network provider in the UnitedHealthcare EPO. Your copayment will be \$25 for each specialist visit.

Some PCPs are affiliated with integrated delivery systems or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by nonaffiliated physicians or facilities. Services provided by nonaffiliated providers may require prior authorization from the Health Plan and/or the integrated delivery system or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment on your first visit. For subsequent visits to receive an allergy injection only, you will not be charged the \$25 copayment. (Routine injections without an office visit are covered at 100%.) If services are for other than an allergy injection, the specialist copayment will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% of covered services after the applicable copayment. If services are for other than a well-woman exam, the specialist copayment will apply. If services are received from your PCP, the PCP copayment will apply.

Routine Care

The UnitedHealthcare EPO offers preventive care services and health screenings to help detect health problems. The following are covered at 100% after a \$15 copayment for each doctor's office visit.

- **Routine physical exam:** well-child care (from birth, including immunizations and booster doses) and adult care, performed by a network provider at a frequency based on American Medical Association guidelines or as directed by a network provider. For frequency guidelines, call UnitedHealthcare;
- **Routine health screenings:**
 - Gynecological exam including Pap smear performed by a network provider annually;
 - Mammogram performed by network provider, at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;

- Sigmoidoscopy annually for persons aged 50 and older;
- Colonoscopy (covered as part of a routine physical);
- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men aged 50 and older;
- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist;
- **Routine hearing exam:** one exam every 24 months, performed by a network otolaryngologist or otologist.

Hospital

Hospital care (inpatient and outpatient) coordinated through a network provider is covered at 100% for covered services.

You do not need to obtain a referral from your PCP to receive the network level of benefits when you receive care coordinated through a network provider.

Maternity

The UnitedHealthcare EPO covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. You and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). If your physician determines that you and your child may be safely discharged after a shorter stay, you will be covered for one home health care visit within 24 hours of your discharge. A copayment does not apply to the home health care visit. See **Hospital services** for more information about hospital stays in connection with childbirth.

You do not need a referral from your PCP for visits to any network provider.

If you are pregnant at the time you join the EPO, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the UnitedHealthcare EPO is your responsibility or that of your previous plan.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital, the copayment is waived. Non-emergency services provided in an emergency room are not covered.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the UnitedHealthcare EPO.

If you have a true medical emergency, you should go to the nearest emergency facility.

If you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact your PCP.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on UnitedHealthcare's Web site. You do not need a referral or any prior authorization to use an urgent care center.

Charges not covered

A network provider contracts with the Claims Administrator to participate in the network. Under the terms of this contract a network provider may not charge you or the Claims Administrator for certain expenses. A network provider cannot charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate.

You may agree with the network provider to pay any charges for services or supplies not covered under the UnitedHealthcare EPO or not approved by the UnitedHealthcare EPO. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the UnitedHealthcare EPO and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see **Claims and appeal for UnitedHealthcare plans**.

Care outside your area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center, or an emergency facility. An urgent medical condition that occurs outside your Health Plan service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

Students can select a PCP near their school or work.

Prescription drugs

The UnitedHealthcare EPO pays, subject to any limitations specified below, the actual expense incurred for outpatient prescription drugs that are in excess of the prescription drug copayment, when you use a network pharmacy. The EPO covers charges for prescription drugs, in excess of the copayment, which are:

- Medically necessary for the care and treatment of an illness;
- Prescribed in writing by a physician;
- Reasonable and customary; and
- Not listed under **Drugs not covered** in this section.

The UnitedHealthcare EPO covers charges for prescription drugs, in excess of the copayment, based on set amounts for each prescription. For more information on these limits, contact UnitedHealthcare directly at 1-877-311-7845.

Your copayments for prescription drugs are as follows:

Generic drug	\$10 copayment
Preferred drug (formulary brand-name drug)	\$20 copayment
Non-preferred drug (non-formulary brand-name drug)	\$40 copayment

Each prescription is limited to a maximum 34-day supply, with up to five refills as authorized by a physician, but not to exceed one year from the date originally prescribed. Prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name drugs.

Coverage is based upon the UnitedHealthcare EPO preferred drug list or “PDL.” The PDL includes both brand-name and generic drugs and is designed to meet outpatient prescription drug needs. You can reduce your copayment by using a generic drug or a brand-name drug that appears on the PDL. Your copayment will be highest if your physician prescribes a brand-name drug that does not appear on the PDL.

Contact UnitedHealthcare EPO for a copy of its PDL.

Maintenance drugs

Participants in UnitedHealthcare EPO who must take maintenance medication — for example, for diabetes or asthma — may be able to obtain a 90-day supply of their maintenance drug through mail order or at a participating pharmacy. Ask the pharmacist at your participating pharmacy whether your maintenance drug is on the list of drugs approved by the EPO for a 90-day supply. If it is included on the list, you will need to ask your physician to give you two prescriptions — the first for a 34-day supply, and the second for your ongoing 90-day maintenance supply. Both the initial supply and the ongoing supply must be obtained from a participating pharmacy.

When you obtain more than a one-month supply of a prescription drug, a separate copayment applies to each month’s supply, unless you use a mail-order pharmacy and obtain a three-month supply.

Mail-order drugs

The UnitedHealthcare EPO covers prescription drugs prescribed by your physician and dispensed by a licensed participating mail-order pharmacy. The drug must be prescribed for at least 35 days, and for no more than 90 days. A single copayment applies to each 90-day supply of medicine dispensed, regardless of quantity.

Your copayments for mail-order drugs are as follows:

Generic drug	\$20 copayment
Preferred drug (formulary brand-name drug)	\$40 copayment
Non-preferred drug (nonformulary brand-name drug)	\$80 copayment

Covered drugs

The UnitedHealthcare EPO covers the following:

- Federal legend drugs, other than those excluded;
- Compounded medication of which at least one ingredient is a legend drug;
- Any other drug under which the applicable state law may be dispensed only upon the written prescription of a physician;
- Insulin;
- Diabetic supplies, as follows:
 - Needles and syringes;
 - Alcohol swabs;
 - Blood glucose testing strips (except electronic devices);

- Urine testing strips/tabs;
- Lancets (excluding administration devices);
- Contraceptive and contraceptive devices, as follows:
 - Oral contraceptives;
 - One diaphragm per 365-day period;
 - Up to five vials of Depo-Provera in a 365-consecutive-day period;
 - Norplant and IUDs are covered when obtained from your PCP or a participating OB/GYN. The office visit copayment will apply when the device is inserted and removed.

Drugs not covered

The UnitedHealthcare EPO does not cover the following services and supplies:

- Any drug that does not, by federal or state law, require a prescription order, even when a prescription is written;
- Prescriptions purchased prior to the effective date of the plan;
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order;
- Drugs labeled "caution — limited by federal law to investigational use" and experimental drugs;
- Drugs prescribed for uses other than the uses approved by the Food and Drug Administration (FDA) under the Food, Drug, and Cosmetic Law and regulations;
- Any prescription for which there is no charge to you;
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth;
- Any medication that is consumed or administered at the place where it is dispensed;
- Medical and non-medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use;
- Immunizations and immunological agents;
- Insulin pumps or tubing for insulin pumps;
- Multivitamins and nutritional supplements, except when they are the only means of nutrition;
- Smoking cessation aids;
- Drugs used for the purpose of weight reduction;
- Drugs prescribed to aid or enhance sexual performance (including Viagra); and
- Drugs used in the treatment of infertility.

Mental health/chemical dependency

United Behavioral Health works with a designated group of participating behavioral health providers and will help direct you to a participating behavioral health provider when needed.

Mental health treatment

Up to 30 days of medically necessary **inpatient** treatment are covered per calendar year (combined with inpatient chemical dependency services). The UnitedHealthcare EPO covers medical, nursing, counseling, and therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. There is no copayment.

The EPO covers medically necessary short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis. Each member is covered for up to 52 outpatient visits per calendar year (combined with outpatient chemical dependency). Each visit is subject to a copayment of \$25.

When approved by the EPO, one day of inpatient treatment may be substituted for two days of partial hospitalization.

Chemical dependency treatment

You may use the mental health benefits described above to cover the following medically necessary services for treatment of chemical dependency:

- Medical, nursing, counseling, and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by your participating provider. A combined maximum of 30 days per calendar year applies to inpatient treatment of mental health and chemical dependency; and
- Outpatient visits to a participating behavioral health provider for diagnostic, medical, or therapeutic rehabilitation services for chemical dependency. There is a \$25 per-visit copayment for outpatient treatment, and a combined calendar year maximum of 52 visits applies to all outpatient visits for mental health and chemical dependency treatment.

Outpatient treatment for chemical dependency or abuse must be provided in accordance with an individualized treatment plan.

Aetna HMO

Type of service	
Annual deductible	▪ None
Maximums	
▪ Annual maximum copayment per employee	▪ None
▪ Annual maximum copayment per family	▪ None
▪ Individual lifetime maximum benefits	▪ Unlimited
Office care	
▪ PCP visit copayment	▪ \$15 copayment per visit
▪ Specialist visit copayment	▪ \$25 copayment per visit
▪ Outpatient surgery in physician's office	▪ \$15 (PCP) or \$25 (specialist) copayment per visit
Allergy treatment	
▪ Allergy testing	▪ \$15 (PCP) or \$25 (specialist) copayment per visit
▪ Allergy injections	▪ \$25 (specialist) copayment for first visit for routine injections, no copayment for subsequent visits
▪ Allergy serum	▪ 100%
Preventive care	
▪ Well-child care and immunizations	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine physical exam	▪ \$15 copayment per visit (subject to frequency limits)
▪ Adult immunizations	▪ \$15 (PCP) copayment per visit
▪ Routine GYN exam/well-woman care	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine eye exam/routine hearing exam	▪ \$15 (PCP) copayment per visit (limited to one eye exam and hearing exam every 24 months)
Lab and x-ray	
▪ Hospital inpatient and outpatient	▪ 100%
▪ X-ray/lab outpatient facility	▪ \$25 copayment per visit
Hospital care and services	
▪ Inpatient surgery	▪ 100%
▪ Outpatient surgery	▪ 100%
Emergency care	
▪ Hospital emergency room	▪ \$50 copayment (waived if admitted)
▪ Ambulance	▪ 100%
▪ Urgent care facility	▪ \$50 copayment per visit

Type of service

Maternity care

- | | |
|-------------------------------|-------------------------------------|
| ▪ Inpatient hospital delivery | ▪ 100% |
| ▪ Office visits (prenatal) | ▪ \$25 copayment (first visit only) |
| ▪ Office visits (postnatal) | ▪ 100% |

Other medical services

- | | |
|---|--|
| ▪ Outpatient therapy (includes speech therapy, physical therapy, and occupational therapy to improve patient's condition) | ▪ \$25 copayment per visit (subject to annual maximum) |
| ▪ Chiropractic care | ▪ \$25 copayment per visit (subject to annual maximum) |
| ▪ Skilled nursing facility | ▪ 100% up to 120-day maximum |
| ▪ Home health care | ▪ 100%, unlimited visits |
| ▪ Hospice care | ▪ 100% |
| ▪ Durable medical equipment (orthotics/prosthetics and appliances) | ▪ 100% |
| ▪ Disposable medical supplies | ▪ 100% |

Infertility treatment

- | | |
|--|----------------------------|
| ▪ Diagnosis and treatment of underlying condition | ▪ \$25 copayment per visit |
| ▪ In vitro fertilization, artificial insemination, and other procedures or treatment to facilitate a pregnancy | ▪ Not covered |

Prescription drugs

- | | |
|--|------------------|
| ▪ Retail (up to 34-day supply) | |
| ▪ Generic | ▪ \$10 copayment |
| ▪ Preferred brand (brand-name formulary) | ▪ \$20 copayment |
| ▪ Non-preferred brand | ▪ \$40 copayment |
| ▪ Mail-order (up to 90-day supply) | |
| ▪ Generic | ▪ \$20 copayment |
| ▪ Preferred brand (brand-name formulary) | ▪ \$40 copayment |
| ▪ Non-preferred brand | ▪ \$80 copayment |

Mental health and chemical dependency

- | | |
|--------------|--|
| ▪ Inpatient | ▪ 100% coverage, 30-day annual maximum* |
| ▪ Outpatient | ▪ \$25 copayment, 52-visit annual maximum* |

* Combined limits for mental health and chemical dependency benefits.

How the Aetna HMO Plan works

Plan participants have access to a network of participating primary care physicians, specialists, and hospitals that meet the Aetna HMO's strict requirements for quality and service. These providers are independent physicians and facilities that are closely monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards, and ongoing training.

Each participant in the Aetna HMO must select a primary care physician (PCP) when he or she enrolls. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

Primary care physician (PCP)

As a participant in the Aetna HMO, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when necessary, your PCP will refer you to other doctors or facilities for treatment. **To receive coverage for such services, you must have a prior written or electronic referral from your PCP for all non-emergency services and any necessary follow-up.** Your copayment will be \$15 for each PCP office visit.

The referral is important for the Aetna HMO because:

- It is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment; and
- It guarantees that you will not have to pay the bill, except any applicable copayment.

Even when your PCP refers you to a specialist or hospital, it is important that he or she keeps track of and coordinates your progress in all stages of your care.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in the Aetna HMO is available at 1-800-821-3808 or online at www.aetna.com.

Specialists

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. Except for those benefits described as **emergency care**, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.

When your PCP refers you to a participating specialist or facility for covered services, your copayment will be \$25 for each specialist visit.

To avoid costly and unnecessary bills, follow these steps:

- Always **consult your PCP first** when you need medical care. If he or she deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the Aetna HMO;
- Certain services require **both** a referral from your PCP **and** prior authorization from the Aetna HMO;
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why;
- Present the referral to the provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services;**
- If it is not an emergency and you go to another doctor or facility without your PCP's prior written or electronic referral, you must pay the bill yourself; and

- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by the Aetna HMO in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from the Aetna HMO (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by nonaffiliated physicians or facilities. Services provided by nonaffiliated providers may require prior authorization from the Aetna HMO and/or the integrated delivery system or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment on your first visit. For subsequent visits to receive an allergy injection only, you will not be charged the \$25 copayment. If services are for other than an allergy injection, the specialist copayment will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% of covered services after the applicable copayment. If services are for other than a well-woman exam, the specialist copayment will apply. If services are received from your PCP, the PCP copayment will apply.

Routine Care

The Aetna HMO Plans offer preventive care services and health screenings to help detect health problems. The following are covered at 100% after a \$15 copayment for each doctor's office visit. Care must be provided or referred by your PCP, except where noted below.

- **Routine physical exam:** well-child care (from birth, including immunizations and booster doses) and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines or as directed by the PCP. For frequency guidelines, call Aetna;
- **Routine health screenings:**
 - Gynecological exam including Pap smear performed by a network provider annually. A referral from your PCP is not required. Any follow-up or related care also may be provided directly by your network gynecologist;
 - Mammogram performed by network provider, at a frequency based on age:
 - Ages 35–39: baseline mammogram, after referral by PCP; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons aged 50 and older;
 - Colonoscopy (covered as part of a routine physical);
 - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men aged 50 and older;
- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist. A referral from your PCP is not required;

- **Routine hearing exam:** one exam every 24 months, performed by a network otolaryngologist or otologist, with a referral from or provided by your PCP;
- **Routine dental exam (for children up to age 12):** one oral exam, cleanings, hygiene instruction, topical application of fluorides and the prescription of fluorides for systematic use when not available in the community water supply (subject to frequency limits).

Hospital

Hospital care (inpatient and outpatient) coordinated through your PCP is covered at 100% for covered services.

If you use a network provider or lab but are *not* referred by your PCP or by a network physician, you will be required to pay the bill based on the negotiated rate contracted with the Claims Administrator.

Maternity

The Aetna HMO covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. You and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). If your physician determines that you and your child may be safely discharged after a shorter stay, you will be covered for one home health care visit within 24 hours of your discharge. A copayment does not apply to the home health care visit. See **Hospital services** for more information about hospital stays in connection with childbirth.

You do not need a referral from your PCP for visits to your participating obstetrician. Your participating obstetrician is responsible for obtaining precertification for all obstetrical care after your first visit. He or she must request approval (precertification) for any tests performed outside of his or her office and for visits to other specialists.

If you are pregnant at the time you join the Aetna HMO, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the Aetna HMO is your responsibility or that of your previous plan.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital, the copayment is waived. Non-emergency services provided in an emergency room are not covered.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Aetna HMO.

If you have a true medical emergency, you should:

- Go to the nearest emergency facility;
- If you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact your PCP; and
- When emergency care has ended, you must get a referral from your PCP before receiving any additional services or notify Aetna HMO prior to receiving any services that require precertification.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on Aetna’s Web site. You do not need a referral or any prior authorization to use an urgent care center.

Charges not covered

A network provider contracts with the Claims Administrator or the Health Plan to participate in the network. Under the terms of this contract a network provider may not charge you or the Claims Administrator for certain expenses. A network provider cannot charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate.

You may agree with the network provider to pay any charges for services or supplies not covered under the Aetna HMO or not approved by the HMO. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the Aetna HMO and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see **Claims and appeals for Aetna medical plans**.

Care outside your area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center, or an emergency facility. An urgent medical condition that occurs outside the Aetna HMO service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to the Aetna HMO by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. The Aetna HMO will send you an emergency room notification report or a Member Services representative can take this information over the telephone.

Prescription drugs

The Aetna HMO pays, subject to any limitations specified below, the actual expense incurred for outpatient prescription drugs that are in excess of the prescription drug copayment, when you use a network pharmacy. The Aetna HMO covers charges for prescription drugs, in excess of the copayment, which are:

- Necessary for the care and treatment of an illness;
- Prescribed in writing by a physician;
- Reasonable and customary; and
- Not listed under **Drugs not covered** in this section.

Your copayments for prescription drugs are as follows:

Generic drug	\$10 copayment
Preferred drug (formulary brand-name drug)	\$20 copayment
Non-preferred drug (non-formulary brand-name drug)	\$40 copayment

Each prescription is limited to a maximum 34-day supply, with up to five refills as authorized by a physician, but not to exceed one year from the date originally prescribed. Prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name drugs.

Coverage is based upon the Aetna HMO medication formulary. The medication formulary includes both brand-name and generic drugs and is designed to meet outpatient prescription drug needs. You can reduce your copayment by using a generic drug or a brand-name drug that appears on the medication formulary. Your copayment will be highest if your physician prescribes a brand-name drug that does not appear on the medication formulary.

Contact Aetna for a copy of this formulary listing.

Maintenance drugs

Participants in the Aetna HMO who must take maintenance medication — for example, for diabetes or asthma — may be able to obtain a 90-day supply of their maintenance drug through mail order or at a participating pharmacy. Ask the pharmacist at your participating pharmacy whether your maintenance drug is on the list of drugs approved by the HMO for a 90-day supply. If it is included on the list, you will need to ask your physician to give you two prescriptions — the first for a 34-day supply, and the second for your ongoing 90-day maintenance supply. Both the initial supply and the ongoing supply must be obtained from a participating pharmacy.

When you obtain more than a one-month supply of a prescription drug, a separate copayment applies to each month’s supply, unless you use a mail order pharmacy and obtain a three-month supply.

Mail-order drugs

The Aetna HMO covers prescription drugs prescribed by your physician and dispensed by a licensed participating mail-order pharmacy. The drug must be prescribed for at least 35 days, and for no more than 90 days. A single copayment applies to each 90-day supply of medicine dispensed, regardless of quantity.

Your copayments for mail-order drugs are as follows:

Generic drug	\$20 copayment
Preferred drug (formulary brand-name drug)	\$40 copayment
Non-preferred drug (nonformulary brand-name drug)	\$80 copayment

Covered drugs

The Aetna HMO covers the following:

- Federal legend drugs, other than those excluded;
- Compounded medication of which at least one ingredient is a legend drug;
- Any other drug under which the applicable state law may be dispensed only upon the written prescription of a physician;
- Insulin;
- Diabetic supplies, as follows:
 - Needles and syringes;
 - Alcohol swabs;
 - Blood glucose testing strips (except electronic devices);

- Urine testing strips/tabs;
- Lancets (excluding administration devices);
- Contraceptive and contraceptive devices, as follows:
 - Oral contraceptives;
 - One diaphragm per 365-day period;
 - Up to five vials of Depo-Provera in a 365-consecutive-day period;
 - Norplant and IUDs are covered when obtained from your PCP or a participating OB/GYN. The office visit copayment will apply when the device is inserted and removed.

Drugs not covered

The Aetna HMO does not cover the following services and supplies:

- Any drug that does not, by federal or state law, require a prescription order, even when a prescription is written;
- Prescriptions purchased prior to the effective date of the plan;
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order;
- Drugs labeled "caution — limited by federal law to investigational use" and experimental drugs;
- Drugs prescribed for uses other than the uses approved by the Food and Drug Administration (FDA) under the Food, Drug, and Cosmetic Law and regulations;
- Any prescription for which there is no charge to you;
- Cosmetics and any drugs used for cosmetic purposes or to promote hair growth;
- Any medication that is consumed or administered at the place where it is dispensed;
- Medical and non-medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use;
- Immunizations and immunological agents;
- Insulin pumps or tubing for insulin pumps;
- Multivitamins and nutritional supplements, except when they are the only means of nutrition;
- Smoking cessation aids;
- Drugs used for the purpose of weight reduction;
- Drugs prescribed to aid or enhance sexual performance; and
- Drugs used in the treatment of infertility.

Mental health/chemical dependency

Each PCP works with a designated group of participating behavioral health providers. Your PCP will help direct you to a participating behavioral health provider when needed.

Mental health treatment

Up to 30 days of **inpatient** treatment are covered per calendar year (combined with inpatient chemical dependency services). The Aetna HMO covers medical, nursing, counseling, and therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. There is no copayment.

The Aetna HMO covers short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis. Each member is covered for up to 52 outpatient visits per calendar year (combined with outpatient chemical dependency). Each visit is subject to a copayment of \$25.

When approved by the Aetna HMO, one day of inpatient treatment may be substituted for two days of partial hospitalization.

Chemical dependency treatment

You may use the mental health benefits described above to cover the following services for treatment of chemical dependency:

- Medical, nursing, counseling, and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by your participating provider. A combined maximum of 30 days per calendar year applies to inpatient treatment of mental health and chemical dependency; and
- Outpatient visits to a participating behavioral health provider for diagnostic, medical, or therapeutic rehabilitation services for chemical dependency. There is a \$25 per-visit copayment for outpatient treatment, and a combined calendar year maximum of 52 visits applies to all outpatient visits for mental health and chemical dependency treatment.

Outpatient treatment for chemical dependency or abuse must be provided in accordance with an individualized treatment plan.

Retrospective Record Review

If you are enrolled in the Aetna HMO, your claims and medical records may be subject to retrospective review. The purpose of retrospective review is to analyze potential quality and utilization issues after services have been provided, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of healthcare services. Aetna's effort to manage the services provided to members includes the retrospective review of claims submitted for payment and of medical records submitted for potential quality and utilization concerns.

Concurrent Review and Discharge Planning

The following items apply if the Aetna HMO requires certification of any confinement, services, supplies, procedures, or treatments:

- **Concurrent Review.** The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require concurrent review.
- **Discharge Planning.** Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.

CIGNA HMO

In Wisconsin, CIGNA refers to its HMO as an EPO.

Type of service	
Annual deductible	▪ None
Maximums	
▪ Annual maximum copayment per employee	▪ None
▪ Annual maximum copayment per family	▪ None
▪ Individual lifetime maximum benefits	▪ Unlimited
Office care	
▪ PCP visit copayment	▪ \$15 copayment per visit
▪ Specialist visit copayment	▪ \$25 copayment per visit
▪ Outpatient surgery in physician's office	▪ 100%
Allergy treatment	
▪ Allergy testing	▪ \$15 (PCP) or \$25 (specialist) copayment per visit
▪ Allergy injections	▪ Copayment included with office visits
▪ Allergy serum	▪ 100%
Preventive care	
▪ Well-child care and immunizations	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine physical exam	▪ \$15 copayment per visit (subject to frequency limits)
▪ Adult immunizations	▪ \$15 (PCP) copayment per visit
▪ Routine GYN exam/well-woman care	▪ \$15 copayment per visit (subject to frequency limits)
▪ Routine eye exam/routine hearing exam	▪ \$15 (PCP) copayment per visit (limited to one eye exam and hearing exam every 24 months)
Lab and x-ray	
▪ Hospital inpatient and outpatient	▪ 100%
▪ X-ray/lab outpatient facility	▪ 100%
Hospital care and services	
▪ Inpatient surgery	▪ 100%
▪ Outpatient surgery	▪ 100%
Emergency care	
▪ Hospital emergency room	▪ \$50 copayment (waived if admitted)
▪ Ambulance	▪ 100%
▪ Urgent care facility	▪ \$15 copayment per visit

Type of service

Maternity care

- | | |
|-------------------------------|-------------------------------------|
| ▪ Inpatient hospital delivery | ▪ 100% |
| ▪ Office visits (prenatal) | ▪ \$25 copayment (first visit only) |
| ▪ Office visits (postnatal) | ▪ 100% |

Other medical services

- | | |
|---|--|
| ▪ Outpatient therapy (includes speech therapy, physical therapy, and occupational therapy to improve patient's condition) | ▪ \$25 copayment per visit (subject to annual maximum) |
| ▪ Chiropractic care | ▪ \$25 copayment per visit (subject to annual maximum) |
| ▪ Skilled nursing facility | ▪ 100%, up to 60-day annual maximum |
| ▪ Home health care | ▪ 100%, unlimited visits |
| ▪ Hospice care | ▪ 100% |
| ▪ Durable medical equipment (orthotics/prosthetics and appliances) | ▪ 100% |
| ▪ Disposable medical supplies | ▪ 100% |

Infertility treatment

- | | |
|--|----------------------------|
| ▪ Diagnosis and treatment of underlying condition | ▪ \$25 copayment per visit |
| ▪ In vitro fertilization, artificial insemination, and other procedures or treatment to facilitate a pregnancy | ▪ Not covered |

Prescription drugs

- | | |
|--|------------------|
| ▪ Retail (up to 30-day supply) | |
| ▪ Generic | ▪ \$10 copayment |
| ▪ Preferred brand (brand-name formulary) | ▪ \$20 copayment |
| ▪ Non-preferred brand | ▪ \$40 copayment |
| ▪ Mail-order (up to 90-day supply) | |
| ▪ Generic | ▪ \$20 copayment |
| ▪ Preferred brand (brand-name formulary) | ▪ \$40 copayment |
| ▪ Non-preferred brand | ▪ \$80 copayment |

Mental health and chemical dependency

- | | |
|--------------|--|
| ▪ Inpatient | ▪ 100% coverage, 30-day annual maximum* |
| ▪ Outpatient | ▪ \$25 copayment, 52-visit annual maximum* |

* Combined limits for mental health and chemical dependency benefits

How the CIGNA HMO Plan works

Plan participants have access to a network of participating primary care physicians, specialists, and hospitals that meet the CIGNA HMO's strict requirements for quality and service. These providers are independent physicians and facilities that are closely monitored for quality of care, patient satisfaction, cost-effectiveness of treatment, office standards, and ongoing training.

Each participant in the CIGNA HMO must select a primary care physician (PCP) when he or she enrolls. Your PCP serves as your guide to care in today's complex medical system and will coordinate and monitor your overall care.

Primary care physician (PCP)

As a participant in the CIGNA HMO, you will become a partner with your participating PCP in preventive medicine. Consult your PCP whenever you have questions about your health. Your PCP will provide your primary care and, when necessary, your PCP will refer you to other doctors or facilities for treatment. **To receive coverage for such services, you must have a prior written or electronic referral from your PCP for all non-emergency services and any necessary follow-up.** Your copayment will be \$15 for each PCP office visit.

The referral is important for the CIGNA HMO because:

- It is how your PCP arranges for you to receive necessary, appropriate care and follow-up treatment; and
- It guarantees that you will not have to pay the bill, except any applicable copayment.

Even when your PCP refers you to a specialist or hospital, it is important that he or she keeps track of and coordinates your progress in all stages of your care.

It is important that you choose a PCP from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in the CIGNA HMO is available at 1-800-794-4953 or online at www.cigna.com/general/misc/docdir.html. If you do not choose a PCP, one will be selected for you

Specialists

Your PCP may refer you to a specialist or facility for treatment or for covered preventive care services, when medically necessary. Except for those benefits described as **emergency care**, you must have a prior written or electronic referral from your PCP in order to receive coverage for any services the specialist or facility provides.

When your PCP refers you to a participating specialist or facility for covered services, your copayment will be \$25 for each specialist visit.

To avoid costly and unnecessary bills, follow these steps:

- Always **consult your PCP first** when you need medical care. If he or she deems it medically necessary, you will get a written or electronic referral to a participating specialist or facility. Referrals are valid for 90 days, as long as you remain an eligible participant in the CIGNA HMO;
- Certain services require **both** a referral from your PCP **and** prior authorization from the CIGNA HMO;
- **Review the referral** with your PCP. Understand what specialist services are being recommended and why;
- Present the referral to the provider. Except for direct access benefits, any additional treatments or tests that are covered benefits require another referral from your PCP. The referral is necessary to have these services approved for payment. **Without the referral, you are responsible for payment for these services;**
- If it is not an emergency and you go to another doctor or facility without your PCP's prior written or electronic referral, you must pay the bill yourself; and

- Your PCP may refer you to a nonparticipating provider for covered services that are not available within the network. Services from nonparticipating providers require prior approval by the CIGNA HMO in addition to a special nonparticipating referral from your PCP. When properly authorized, these services are covered after the applicable copayment.

You cannot request referrals **after** you visit a specialist or hospital. Therefore, to receive maximum coverage, you need to contact your PCP and get authorization from the CIGNA HMO (when applicable) **before** seeking specialty or hospital care.

Some PCPs are affiliated with integrated delivery systems or other provider groups (such as Independent Practice Associations and Physician-Hospital Associations). If your PCP participates in such an arrangement, you will usually be referred to specialists and hospitals within that system or group. However, if your medical needs extend beyond the scope of the affiliated providers, you may ask to have services provided by nonaffiliated physicians or facilities. Services provided by nonaffiliated providers may require prior authorization from CIGNA HMO and/or the integrated delivery system or other provider group. Check with your PCP or call the Member Services number that appears on your ID card to find out if prior authorization is necessary.

Allergist: When you see a network allergist, you will be expected to make the specialist copayment on your first visit. Routine injections without a doctor's office visit are covered at 100%. If services are for other than an allergy injection, the specialist copayment will apply.

OB/GYN: You or your dependent can go to a network OB/GYN for a well-woman exam without a referral from a PCP. Any procedures, tests, or lab work done as part of the well-woman visit are covered at 100% of covered services after the applicable copayment. If services are for other than a well-woman exam, the specialist copayment will apply. If services are received from your PCP, the PCP copayment will apply.

Routine Care

The CIGNA HMO Plan offers preventive care services and health screenings to help detect health problems. The following are covered at 100% after a \$15 copayment for each doctor's office visit. Care must be provided or referred by your PCP, except where noted below.

- **Routine physical exam:** well-child care (from birth, including immunizations and booster doses) and adult care, performed by the patient's PCP at a frequency based on American Medical Association guidelines or as directed by the PCP. For frequency guidelines, call CIGNA;
- **Routine health screenings:**
 - Gynecological exam including Pap smear performed by a network provider annually. A referral from your PCP is not required. Any follow-up or related care also may be provided directly by your network gynecologist;
 - Mammogram performed by network provider, at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons aged 50 and older;
 - Colonoscopy (covered as part of a routine physical);
 - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men aged 50 and older;

- **Routine eye exam:** one exam every 24 months, performed by a network ophthalmologist or optometrist. A referral from your PCP is not required;
- **Routine hearing exam:** covered as part of a routine physical performed by your PCP.

Hospital

Hospital care (inpatient and outpatient) coordinated through your PCP is covered at 100% for covered services.

If you use a network provider or lab but are *not* referred by your PCP or by a network physician, you will be required to pay the bill based on the negotiated rate contracted with the Claims Administrator.

Maternity

The CIGNA HMO Plan covers physician and hospital care for mother and baby, including prenatal care, delivery and postpartum care. You and your newly born child are covered for a minimum of 48 hours of inpatient care following a vaginal delivery (96 hours following a cesarean section). If your physician determines that you and your child may be safely discharged after a shorter stay, you will be covered for one home health care visit within 24 hours of your discharge. A copayment does not apply to the home health care visit. See **Hospital services** for more information about hospital stays in connection with childbirth.

You do not need a referral from your PCP for visits to your participating obstetrician. Your participating obstetrician is responsible for obtaining precertification for all obstetrical care after your first visit. He or she must request approval (precertification) for any tests performed outside of his or her office and for visits to other specialists

If you are pregnant at the time you join the CIGNA HMO, you receive coverage for authorized care from participating providers **on and after your effective date**. There is no waiting period. Coverage for services incurred prior to your effective date with the CIGNA HMO is your responsibility or that of your previous plan.

Emergency care

The emergency room copayment is \$50 per visit. If you are admitted to the hospital, the copayment is waived. Non-emergency services provided in an emergency room are not covered.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should:

- Go to the nearest emergency facility;
- If you are admitted, you must contact your PCP within 48 hours. If you are unable to do this, have a family member contact your PCP; and
- When emergency care has ended, you must get a referral from your PCP before receiving any additional services or notify CIGNA HMO prior to receiving any services that require precertification.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a PCP is not available. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures).

Urgent care centers are listed in the provider directory that can be accessed on CIGNA's Web site. You do not need a referral or any prior authorization to use an urgent care center.

Charges not covered

A network provider contracts with the Claims Administrator or the CIGNA HMO to participate in the network. Under the terms of this contract a network provider may not charge you or the Claims Administrator for certain expenses. A network provider cannot charge you or the Claims Administrator for the balance of the charges above the contracted negotiated rate.

You may agree with the network provider to pay any charges for services or supplies not covered under the CIGNA HMO or not approved by the HMO. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the CIGNA HMO and are not payable by the Claims Administrator.

For information about how to file a claim or appeal a denied claim, see **Claims and appeals for CIGNA medical plans**.

Care outside your area

Plan participants who are traveling outside the service area, or students who are away at school, are covered for emergency care and treatment of urgent medical conditions. Urgent care may be obtained from a private practice physician, a walk-in clinic, an urgent care center, or an emergency facility. An urgent medical condition that occurs outside the CIGNA HMO service area can be treated in any of the above settings. You should call your PCP as soon as possible after receiving treatment.

If, after reviewing information submitted to the CIGNA HMO by the provider(s) who supplied your care, the nature of the urgent or emergency problem does not clearly qualify for coverage, it may be necessary to provide additional information. The HMO will send you an emergency room notification report or a Member Services representative can take this information over the telephone.

Prescription drugs

The CIGNA HMO pays, subject to any limitations specified below, the actual expense incurred for outpatient prescription drugs that are in excess of the prescription drug copayment, when you use a network pharmacy. The HMO covers charges for prescription drugs, in excess of the copayment, which are:

- Necessary for the care and treatment of an illness;
- Prescribed in writing by a physician;
- Reasonable and customary; and
- Not listed under **Drugs not covered** in this section.

Your copayments for prescription drugs are as follows:

Generic drug	\$10 copayment
Preferred drug (formulary brand-name drug)	\$20 copayment
Non-preferred drug (non-formulary brand-name drug)	\$40 copayment

Each prescription is limited to a maximum 30-day supply, with up to five refills as authorized by a physician, but not to exceed one year from the date originally prescribed. Prescriptions must be filled at a participating pharmacy. Generic drugs may be substituted for brand-name drugs.

Coverage is based upon the CIGNA HMO medication formulary. The medication formulary includes both brand-name and generic drugs and is designed to meet outpatient prescription drug needs. You can reduce your copayment by using a generic drug or a brand-name drug that appears on the medication formulary. Your copayment will be highest if your physician prescribes a brand-name drug that does not appear on the medication formulary.

Contact CIGNA for a copy of this formulary listing.

Maintenance drugs

Participants in the CIGNA HMO who must take maintenance medication — for example, for diabetes or asthma — may be able to obtain a 90-day supply of their maintenance drug through mail order or at a participating pharmacy. Ask the pharmacist at your participating pharmacy whether your maintenance drug is on the list of drugs approved by the HMO for a 90-day supply. If it is included on the list, you will need to ask your physician to give you two prescriptions — the first for a 30-day supply, and the second for your ongoing 90-day maintenance supply. Both the initial supply and the ongoing supply must be obtained from a participating pharmacy.

When you obtain more than a one-month supply of a prescription drug, a separate copayment applies to each month’s supply, unless you use a mail order pharmacy and obtain a three-month supply.

Mail-order drugs

CIGNA HMO covers prescription drugs prescribed by your physician and dispensed by a licensed participating mail-order pharmacy. The drug must be prescribed for at least 30 days, and for no more than 90 days. A single copayment applies to each 90-day supply of medicine dispensed, regardless of quantity.

Your copayments for mail-order drugs are as follows:

Generic drug	\$20 copayment
Preferred drug (formulary brand-name drug)	\$40 copayment
Non-preferred drug (nonformulary brand-name drug)	\$80 copayment

Covered drugs

The CIGNA HMO covers the following:

- Legend drugs, other than those excluded;
- Compounded medication of which at least one ingredient is a legend drug;
- Any other drug under which the applicable state law may be dispensed only upon the written prescription of a physician;
- Insulin;
- Diabetic supplies, as follows:
 - Needles and syringes;
 - Alcohol swabs;
 - Blood glucose testing strips (except electronic devices);

- Urine testing strips/tabs;
- Lancets (excluding administration devices);
- Contraceptive and contraceptive devices, as follows:
 - Oral contraceptives;
 - One diaphragm per 365-day period;
 - Up to five vials of Depo-Provera in a 365-consecutive-day period;
 - Norplant and IUDs are covered when obtained from your PCP or a participating OB/GYN. The office visit copayment will apply when the device is inserted and removed.

Drugs not covered

CIGNA HMO does not cover the following services and supplies:

- Any drug that does not, by federal or state law, require a prescription order, even when a prescription is written;
- Prescriptions purchased prior to the effective date of the plan;
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order;
- Drugs labeled "caution — limited by federal law to investigational use" and experimental drugs;
- Drugs prescribed for uses other than the uses approved by the Food and Drug Administration (FDA) under the Food, Drug, and Cosmetic Law and regulations;
- Any prescription for which there is no charge to you;
- Cosmetics and any drugs used for cosmetic purpose or to promote hair growth;
- Any medication that is consumed or administered at the place where it is dispensed;
- Medical and non-medical supplies, devices and equipment, and non-medical supplies and substances, regardless of their intended use;
- Immunizations and immunological agents;
- Insulin pumps or tubing for insulin pumps;
- Multivitamins and nutritional supplements, except when they are the only means of nutrition;
- Smoking cessation aids;
- Drugs used for the purpose of weight reduction;
- Drugs prescribed to aid or enhance sexual performance; and
- Drugs used in the treatment of infertility.

Mental health/chemical dependency

Each PCP works with a designated group of participating behavioral health providers. Your PCP will help direct you to a participating behavioral health provider when needed.

Mental health treatment

Up to 30 days of **inpatient** treatment are covered per calendar year (combined with inpatient chemical dependency services). The CIGNA HMO covers medical, nursing, counseling, and therapeutic services in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health or its equivalent. There is no copayment.

The CIGNA HMO covers short-term evaluation and crisis intervention mental health services provided on an **outpatient** basis. Each member is covered for up to 52 outpatient visits per calendar year (combined with outpatient chemical dependency). Each visit is subject to a copayment of \$25.

When approved by the HMO, one day of inpatient treatment may be substituted for two days of partial hospitalization.

Chemical dependency treatment

You may use the mental health benefits described above to cover the following services for treatment of chemical dependency:

- Medical, nursing, counseling, and therapeutic rehabilitation services for treatment of alcohol or drug abuse or dependency in an inpatient, non-hospital residential facility, appropriately licensed by the Department of Health, upon referral by your participating provider. A combined maximum of 30 days per calendar year applies to inpatient treatment of mental health and chemical dependency; and
- Outpatient visits to a participating behavioral health provider for diagnostic, medical, or therapeutic rehabilitation services for chemical dependency. There is a \$25 per-visit copayment for outpatient treatment, and a combined calendar year maximum of 52 visits applies to all outpatient visits for mental health and chemical dependency treatment.

Outpatient treatment for chemical dependency or abuse must be provided in accordance with an individualized treatment plan.

Health Plan 200 — Hawaii Only

Health Plan 200 is available in Hawaii only and is administered by UnitedHealthcare. You can save money by using UnitedHealthcare's preferred providers.

Type of service	Health Plan 200 (<i>UnitedHealthcare — available in Hawaii only</i>)
Annual deductible	
▪ Individual	▪ \$200
▪ Maximum per family	▪ \$600
Annual out-of-pocket maximum (includes deductible)	
▪ Individual	▪ \$1,000
▪ Maximum per family	▪ \$2,000
Lifetime maximum	▪ \$3 million
Professional care (in office)	
▪ PCP or specialist visits	▪ 90% after deductible when using preferred providers; 80% of R&C after deductible when using non-preferred providers
Routine care (subject to frequency limits)	
▪ Well-adult	▪ 80%, no deductible
▪ Well-child and immunizations	▪ 80%, no deductible
Hospital inpatient and outpatient	
▪ Semiprivate room and board, doctor's charges, lab, x-ray, and surgical care	<ul style="list-style-type: none"> ▪ Inpatient: 90% after deductible when using preferred physicians; 80% of R&C after deductible when using preferred hospital; 80% after deductible when using non-preferred physicians; 80% of R&C after \$100 confinement deductible and calendar year deductible when using non-preferred hospitals ▪ Outpatient: 90% after deductible when using preferred physician; 80% of R&C after deductible when using non-preferred physician; 80% of R&C after deductible for hospital
Emergency care	
▪ No coverage if not a true emergency	▪ 90% after deductible for physician; 80% after deductible for hospital
Urgent care center	▪ 90% after deductible when using preferred providers; 80% of R&C after deductible when using non-preferred providers
Prescription drugs (refer to <u>Prescription drug program</u>)	
Mental health and chemical dependency (refer to <u>Mental health/chemical dependency</u>)	

This chart is intended as a brief summary of benefits. Not all covered services, exclusions, and limitations are shown. For additional information and/or clarification of benefits, see **Covered services and supplies** and **Exclusions and limitations**.

How the Plan works

This section contains more detailed information about Health Plan 200's provisions and how the medical plan option works.

You have a choice of using preferred providers or non-preferred providers. Using preferred providers saves you money in two ways. First, preferred providers charge negotiated rates, which are generally lower than the R&C charges. Second, the level of benefits is generally higher when you use a preferred provider.

A directory of preferred providers is available directly from UnitedHealthcare by calling 1-877-311-7845 or by visiting the Web site at www.provider.uhc.com/citigroup.

For information about how to file a claim or appeal a denied claim, see [Claims and appeals for UnitedHealthcare plans](#).

Deductibles and coinsurance

You must meet an annual deductible of \$200 individual (\$600 family maximum) before Health Plan 200 pays any benefits. There is no annual deductible for routine preventive care.

The individual deductible applies to all covered expenses except routine preventive care and must be satisfied each calendar year before any benefits will be paid.

The family deductible is the most a family will have to pay in individual deductibles in any calendar year. Only covered expenses that count toward your or your dependent's individual deductible count toward the family deductible. The family deductible can be met as follows:

- **Up to two in a family:** each member must meet the \$200 individual deductible; or
- **Three or more in a family:** expenses can be combined to meet the \$600 family deductible, but no one person can apply more than the \$200 individual deductible toward the family deductible amount.

Once you have satisfied the deductible, Health Plan 200 normally pays 90% of the negotiated rate for covered health services if you or your covered dependent uses a UnitedHealthcare preferred physician, and pays 80% of R&C if you use a UnitedHealthcare preferred hospital.

Out-of-pocket maximum

Your individual out-of-pocket maximum is \$1,000 (\$2,000 family maximum). The amount includes the \$200 individual (\$600 family) deductible. There is a lifetime maximum of \$3 million. Once this out-of-pocket maximum is met, covered expenses are payable for the remainder of the calendar year at 100% of the negotiated rate when you use a preferred provider or at 100% of R&C when you use a non-preferred provider.

Eligible expenses 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 (\$1,000) to the family out-of-pocket maximum (\$2,000).

Not all expenses count toward your out-of-pocket maximum. Among those that do *not* count are expenses that exceed R&C, pharmacy copayments, any coinsurance charges for mental health and chemical dependency treatment, and penalties applied for failure to notify UnitedHealthcare.

Routine care

Well-child care, adult routine physical exams, and routine health screenings are covered at:

- 80% of the negotiated rate (for care received from a UnitedHealthcare preferred provider); and
- 80% of R&C (for care received from a non-preferred provider).

The annual deductible does not apply to routine care; however, routine care is subject to the following limits:

- **Routine physical exam:** well-child care and adult care at a frequency based on American Medical Association (AMA) guidelines. For frequency guidelines, call UnitedHealthcare at 1-877-311-7845;
- **Routine health screenings:**
 - Gynecological exam, including annual Pap smear;
 - Mammogram at a frequency based on age:
 - Ages 35–39: baseline mammogram; or
 - Age 40 and older: annual mammogram;
 - Sigmoidoscopy annually for persons age 50 and older;
 - Colonoscopy (covered as part of a routine physical); and
 - Prostatic-specific antigen (PSA) screening.

All routine care is covered at 80% of the negotiated rate for preferred providers or 80% of R&C for non-preferred providers. There is no deductible or annual maximum for routine physicals.

To be sure your claim for a routine exam is paid properly, ask your physician to indicate “routine exam” on the bill. If a medical condition is diagnosed during a routine exam, your claim for a routine exam still will be paid as explained above, provided the bill is marked “routine exam.”

Infertility

Health Plan 200 covers medical *and* pharmacy expenses associated with infertility treatment, subject to the following limits:

- Medical expenses up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000, in a medical option managed by UnitedHealthcare only;
- Prescription drug expenses associated with infertility treatment up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

Note: Coverage for prescription drugs used to treat infertility is provided through the **Prescription drug program**. The limits on coverage for drugs to treat infertility are in addition to any other prescription drug limits or requirements.

These coverage limits include infertility treatment in-network and out-of-network and across all UnitedHealthcare plans combined.

In order to be eligible for infertility benefits, you or your eligible dependent must have a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

For more specific information, contact UnitedHealthcare directly.

Hospital

After you meet your annual deductible, hospital care (inpatient and outpatient) will be reimbursed at:

- 80% of the negotiated rate for claims incurred at a UnitedHealthcare preferred hospital; and
- 80% of R&C after the \$100 per confinement deductible for claims incurred at a non-preferred hospital in an area where one was available.

Notification is required for hospitalization, facility admissions, and certain outpatient procedures and services. For more information, see **Precertification/notification**.

Emergency care

After you satisfy the deductible, emergency care is covered at 80% for covered hospital services and 90% for covered physician services. Non-emergency services provided in an emergency room are not covered.

See the **Glossary** for the definition and examples of emergency care as defined and determined by the Health Plans.

If you have a true medical emergency, you should go to the nearest emergency facility. If you are admitted, you must contact UnitedHealthcare within 48 hours. If you are not able to do this, have a family member contact UnitedHealthcare or a \$500 penalty may apply. See **Precertification/notification**.

Urgent care

Urgent care centers consist of a network of physicians that may be used when immediate care is needed. The centers usually have evening and weekend hours and do not require an appointment. The centers may be used when you or a covered dependent needs immediate care (for example, for a high fever, a severe rash, the flu) but does not need the services of a hospital emergency room (for example, for chest pains, poisonings, seizures). Urgent care centers will be reimbursed at:

- 90% of the negotiated rate (after deductible) for care received by a UnitedHealthcare preferred provider; or
- 80% of R&C (after deductible) for claims submitted by a non-preferred provider.

Mental health/chemical dependency

Health Plan 200 provides confidential mental health and chemical dependency coverage through a network of participating counselors and specialized practitioners.

When you call UnitedHealthcare at the telephone number on your ID card, you will be put in touch with an intake coordinator who will gather information from you and help you find the right care provider. In an emergency, the intake coordinator also will provide immediate assistance, and, if necessary, arrange for treatment in an appropriate facility.

You must call UnitedHealthcare before seeking treatment for mental health or chemical dependency treatment. For more information, see **Precertification/notification**.

A directory of participating providers is available directly from UnitedHealthcare at 1-877-311-7845 or online at **www.provider.uhc.com/citigroup**.

Action	Inpatient	Outpatient
If you call UnitedHealthcare and use its network provider/facility	After the deductible, eligible expenses covered at 80% of the negotiated rate; maximum of 30 days per calendar year*	No deductible; \$25 copayment per visit; maximum benefit of 52 visits per calendar year.
If you call UnitedHealthcare but do not use its network provider/facility	After a \$100 confinement deductible and after the \$200 individual deductible, eligible expenses covered at 50% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*
If you do not call and do not use UnitedHealthcare's network provider/facility	\$500 non-notification penalty per occurrence; after a \$100 confinement deductible and the \$200 deductible, eligible expenses covered at 50% of R&C; maximum benefit of 30 days per calendar year*	After the deductible, eligible expenses covered at 50% of R&C; maximum benefit of 52 visits per calendar year*

* Maximum benefits are combined for network and out-of-network services.

Coverage levels

Unlike the medical benefits under Health Plan 200, mental health and chemical dependency treatment benefits are subject to medical necessity requirements, as well as being subject to the same coverage guidelines and deductibles that are required under Health Plan 200. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required under Health Plan 200.

Mental Health benefits include, but are not limited to:

- Assessment;
- Diagnosis;
- Treatment planning;
- Medication management;
- Individual, family, and group psychotherapy;
- Psychological education; and
- Psychological testing.

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

Mental health/chemical dependency treatment expenses, including copayments, do not count toward your calendar year out-of-pocket maximum.

Inpatient services

You *must* call UnitedHealthcare to give notification of inpatient services or a \$500 penalty may apply in each occurrence.

Inpatient services are covered only if they are determined to be medically necessary and there is no less intensive or more appropriate level of care in lieu of an inpatient hospital stay. There is a maximum benefit of 30 days per calendar year for inpatient services. If it is determined that a less intensive or more appropriate level of treatment could have been given, no benefits will be payable.

Generally, inpatient services must be rendered in the state in which the patient resides, unless approved by UnitedHealthcare in advance of the admission.

Outpatient services

You are encouraged to call UnitedHealthcare for outpatient referrals, although a referral is not required. If you call UnitedHealthcare and use network providers, you will pay only a \$25 copayment per visit. If you do not use UnitedHealthcare's recommended providers, you will be reimbursed for 50% of R&C for covered services after the deductible is met.

Note: There is a maximum benefit of 52 visits per calendar year for outpatient services, based on medical necessity.

Emergency care

Emergency care does not require a referral from UnitedHealthcare. When emergency care is required for mental health or chemical dependency treatment, you (or your representative or physician) must call UnitedHealthcare within 48 hours after the emergency care is given. UnitedHealthcare's behavioral health provider is available 24 hours a day, seven days a week to accept calls.

When emergency care has ended, you should call UnitedHealthcare for any additional inpatient services. Otherwise, benefits may be reduced. All benefits, as long as they are deemed medically necessary, are payable as shown in the highlights chart.

No medical necessity (except for mental health/chemical dependency benefits)

Health Plan 200 provides coverage based on the benefits described in this summary plan description. There is no determination of medical necessity.

Medically necessary — mental health/chemical dependency benefits

UnitedHealthcare's behavioral health provider will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. UnitedHealthcare's behavioral health provider will determine whether certain covered services and supplies are medically necessary solely for purposes of determining what the medical plans will reimburse. No benefits are payable unless UnitedHealthcare's behavioral health provider determines that the covered services and supplies are medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Plan. Please refer to the **Glossary** for a definition of medical necessity.

For more information about coverage for a particular service or supply or limits that may apply, see **Covered services and supplies** or call UnitedHealthcare at 1-877-311-7845.

Prescription drug program

The prescription drug program described in this section is administered by Medco Health Solutions, Inc., and applies to participants enrolled in the Point-of-Service, Health Plan 200, Health Plan 200, and the Out-of-Area plans.

HMO participants are not eligible for the prescription drug benefits described in this section. Each HMO has its own retail and mail-order pharmacy program. For information about your HMO's prescription drug program, see **Health Maintenance Organization(s)**.

Medco Health Solutions, Inc. administers the prescription drug program through the following affiliates:

- Medco Health Prescription Solutions, Inc. — for the retail pharmacy program; and
- Medco Health Home Delivery Pharmacy Service — for the home delivery pharmacy service program (mail order pharmacy).

Feature	Retail	Home Delivery Pharmacy
When to use	When you need a prescription drug on a short-term basis. For example, an antibiotic to treat an infection.	For prescription drugs you use on a regular basis. For example, maintenance drugs to treat asthma or diabetes.
Quantity available for each prescription or refill	Up to a 34-day supply.	Up to a 90-day supply with refills for up to one year.
Your copayment for each prescription or refill*	At network pharmacies: <ul style="list-style-type: none"> ▪ \$10 for a generic drug. ▪ \$20 for a preferred brand-name drug. ▪ 50% of the cost of the drug with a minimum payment of \$40 to a maximum payment of \$75 for a non-preferred brand-name drug. 	<ul style="list-style-type: none"> ▪ \$20 for a generic drug. ▪ \$40 for a preferred brand-name drug. ▪ 50% of the cost of the drug with a minimum payment of \$80 to a maximum payment of \$150 for a non-preferred brand-name drug.
	Note: If you request a brand-name drug and a generic alternative is available, you will pay the difference between the cost of the brand-name drug and the generic drug, plus you will pay the generic copayment.	Note: If you request a brand-name drug and a generic alternative is available, you will pay the difference between the cost of the brand-name drug and the generic drug, plus you will pay the generic copayment.
	At out-of-network pharmacies: <ul style="list-style-type: none"> ▪ For non-emergencies: You will be reimbursed for 50% of the covered drug cost after filing a claim. 	

-
- For emergencies:
Reimbursement for all but the network copayment may be available. Please call your Benefit Service Center.
-

** Pharmacy and/or home delivery copayments do not count toward satisfaction of your annual deductible or out-of-pocket maximum.*

Medco's Preferred Prescriptions Formulary is a list of drugs carefully selected by an independent pharmacy and therapeutic committee to help maintain quality care while saving money for both you and Citigroup. Since the list of preferred brand-name drugs is reviewed on a quarterly basis, your copayment for a drug may change during the year. To see whether your prescription is still on the list of preferred brand-name drugs, call Member Services at 1-800-987-8369 or visit www.medcohealth.com.

Prescription drugs for the treatment of infertility are covered up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500.

Retail pharmacy

When you enroll in a Health Plan, you will be issued a prescription ID card. When you present the prescription ID card at a participating pharmacy, you will pay a copayment for up to a 34-day supply of your prescription.

Some drugs may require a letter of medical necessity from your physician to be filled. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

Using a network pharmacy

You must present your prescription ID card at the network pharmacy to take advantage of the network copayments. Network pharmacies dispense generic drugs whenever possible. The generic drug copayment is \$10 for each prescription. If your physician writes "Dispense As Written" on the prescription or if your physician prescribes a drug for which there is no generic equivalent, your copayment is \$20 for a preferred brand-name drug or 50% of the cost of the drug, with a minimum payment of \$40 to a maximum payment of \$75, for a non-preferred brand-name drug. If the cost of the drug is less than the copayment, you will pay the lesser cost.

You can locate a network pharmacy by calling Member Services at 1-800-987-8369 or by visiting the Web site at www.medcohealth.com.

Using an out-of-network pharmacy

If you use an out-of-network pharmacy or you fail to present your prescription ID card at a network pharmacy at the time the prescription is filled, you must pay the entire cost of the prescription and then submit a claim form. You will be reimbursed for 50% of the prescription drug cost.

If you use an out-of-network pharmacy during an emergency care situation, you must pay the entire cost of the prescription drug and then submit the claim form. Reimbursement for the cost, except the network deductible, may be available. You should contact your Benefit Service Center for information regarding coverage in emergencies.

Send all completed claim forms to:

Medco Health Prescription Solutions, Inc.
P.O. Box 2187
Lee's Summit, MO 64063-2187

Home delivery pharmacy service

The home delivery pharmacy service fills prescriptions for up to a 90-day supply of maintenance drugs.

Copayments are:

- \$20 for a generic drug;
- \$40 for a preferred brand-name drug; and
- 50% of the cost of the drug with a minimum payment of \$80 to a maximum payment of \$150 for a non-preferred brand-name drug.

The drugs prescribed must be medically necessary for the diagnosis for which they are prescribed.

The original prescription must indicate that a 90-day supply is needed, not including refills.

Participants will receive a mail service order form in the Member Welcome Kit. Additional forms can be obtained by calling Member Services at 1-800-987-8369 or visiting the Web site at www.medcohealth.com.

Send all completed home delivery pharmacy service order forms to:

Medco Health Solutions, Inc.
P.O. Box 182050
Cincinnati, OH 43218-2050

Covered drugs

The following drugs and products are covered under the prescription drug program:

- Federal legend drugs;
- State restricted drugs;
- Compounded medications of which at least one ingredient is a legend drug;
- Insulin;
- Needles and syringes;
- Over the counter (OTC) diabetic supplies (except blood glucose testing monitors);
- Oral and injectable contraceptives — up to a 90-day supply;
- Fertility agents;
- Legend vitamins;
- Amphetamines through age 18;
- Drugs to treat impotency for males age 18 and older (quantity limits apply);
- Retin-A/Avita (cream only) through age 34; and
- Retin-A/Avita (all other dosage forms) through age 34.

Some drugs require pre-authorization. They include:

- Legend anti-obesity preparations;

- Amphetamines at age 19 and over; and
- Retin-A/Avita (cream only) at age 35 and over.

If the prescribed medication must be pre-authorized, the pharmacy will let you know if additional information is required by your plan. You or the pharmacy can then ask your doctor to call a special toll-free number. This call will initiate a review that typically takes one to two business days. You and your physician will be notified when the review is completed. If your medication is not approved, you will have to pay the full cost of the prescription drug.

There are also coverage limits for some categories of drugs. These categories include:

- Erectile dysfunction;
- Anti-influenza (retail only); and
- Smoking deterrents.

Drugs not covered

The following drugs and products are not covered under the prescription drug program:

- Non-federal legend drugs;
- Contraceptive jellies, creams, foams, devices, or implants;
- Drugs to treat impotency for all females and males through age 17;
- Irrigants;
- Relenza*;
- Retin-A/Avita (all non cream dosage forms) at age 35 and over;
- Tamiflu*;
- Topical fluoride products;
- Blood glucose testing monitors;
- Therapeutic devices or appliances;
- Drugs whose sole purpose is to promote or stimulate hair growth (e.g., Rogaine®, Propecia®) or for cosmetic purposes only (e.g., Renova®);
- Allergy sera;
- Immunization agents and vaccines;
- 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 which 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 which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals;
- 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.

** Home delivery pharmacy service exclusion only; covered by retail pharmacy.*

Precertification/notification

Precertification/notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting, and that your health care costs and Citigroup's costs are kept under control. The following sections describe the precertification/notification features of each health plan. Be sure to read the sections that apply to the plan available to you.

UnitedHealthcare plans — Care Coordination Program

For all plans administered by UnitedHealthcare (Select Plus plan, Health Plan 2000, Health Plan 200, and the Out-of-Area Health Plan).

The Care Coordination Program is UnitedHealthcare's alternative to precertification and is designed to encourage the identification and follow-up of covered health care needs.

Notification

The following services require notifying the Care Coordination Program if you are enrolled in one of the Citigroup Medical Plans listed above or use out-of-network services under the Select Plus plan:

- Hospital and other facility admissions, including emergency admissions;
- Home health care services, including private duty nursing;
- Reconstructive procedures;
- Hospice care;
- Maternity admissions exceeding 48 hours for normal delivery/96 hours for cesarean section;
- Dental services (accident only);
- Durable medical equipment with a retail cost of more than \$1,000 whether for purchase or rental; and
- Transplant services.

If you are enrolled in a UnitedHealthcare plan, you do not have to precertify. However, you are required to notify UnitedHealthcare of any inpatient hospital stays, facility admissions, and certain outpatient procedures and services by calling the number on your ID card. Scheduled inpatient services and certain outpatient procedures require notification at least five days in advance. UnitedHealthcare must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify the carrier of emergency hospitalization or other emergency services occurring outside the U.S.

Select Plus Network services: please keep in mind that your PCP will handle the notification process for you when you receive any in-network services.

Select Plus Out-of-Network services: when you receive care from an out-of-network provider, you must notify UnitedHealthcare before receiving any of the listed services.

Health Plan 2000, Health Plan 200, and the Out-of-Area plan: when you receive care from any provider, whether in-network or out-of-network, you must notify UnitedHealthcare before receiving any of the listed services.

Non-notification penalty

If you do not notify UnitedHealthcare in advance of certain procedures (listed in the **Notification** section), or if you choose to ignore UnitedHealthcare's advice, your benefits may be reimbursed at a lower level and certain penalties will apply:

- For care that otherwise would have been approved had UnitedHealthcare been notified, your benefits will be subject to a non-notification penalty each time UnitedHealthcare is not notified; and
- For care that would not have been approved, no benefit is payable.

None of the penalty charges will be applied toward your annual out-of-pocket maximum.

The ultimate decisions about medical care must be made by you and your physician. UnitedHealthcare will determine coverage solely for purposes of deciding which goods and services are covered services.

Approval by UnitedHealthcare does not guarantee that benefits are payable under the Citigroup Inc. Medical Benefits Plan. Benefits are based on:

- The covered services and supplies actually performed or given;
- Your eligibility under the UnitedHealthcare plan on the date the covered services and supplies are performed or given; and
- Copayments, deductibles, coinsurance, maximum limits, and all other terms of the UnitedHealthcare plan.

Inpatient confinements

For inpatient confinement in a hospital or other facility, you must notify UnitedHealthcare of the scheduled admission date at least five days before the start of the confinement. An admission date may not have been set when the confinement was planned. You must call UnitedHealthcare again as soon as the admission date is set. If you do not notify UnitedHealthcare, you will be charged a non-notification penalty of \$500 or the amount of the covered charge, whichever is less. The penalty will be deducted from your reimbursement under the UnitedHealthcare plan. It will not apply toward your deductible or out-of-pocket maximum.

You must notify UnitedHealthcare for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call *within* 48 hours after the admission.

Outpatient surgery/diagnostic testing/other services

If you do not notify UnitedHealthcare of certain outpatient services, you will be charged a non-notification penalty of \$200 or the amount of the covered charge, whichever is less. The penalty will be deducted from your reimbursement under the UnitedHealthcare plan. It will not apply toward your deductible or out-of-pocket maximum.

When you receive care from an out-of-network provider, you must notify UnitedHealthcare before receiving the following services:

- Diagnostic tests for organ or tissue transplants;
- Reconstructive procedures;
- Home health care;
- Private duty nursing;
- Hospice;
- Dental services (accident only); and
- Durable medical equipment with a purchase or cumulative rental cost of \$1,000 or more.

For outpatient services that require notification, you must notify UnitedHealthcare at least five working days before the service is given.

Mental health/chemical dependency

You must notify UnitedHealthcare before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify UnitedHealthcare at least seven working days before the scheduled date of any of the following, or as soon as reasonably possible:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

Pregnancy

Pregnancy is subject to the following notification time periods:

- UnitedHealthcare should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program.
- For inpatient care (for either the mother or child) that continues beyond 48 hours following a normal vaginal delivery or 96 hours following a cesarean section, UnitedHealthcare must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician do not agree with UnitedHealthcare's determination, you may appeal the decision. For information about the claims appeal process, see **Claims and appeals for UnitedHealthcare plans**.

Aetna plans

If you are enrolled in an Aetna plan, you must call Aetna to precertify any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services must be precertified at least 14 days in advance. Outpatient procedures must be precertified at least five days in advance. Aetna must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify the carrier of emergency hospitalization or other emergency services occurring outside the U.S.

Non-precertification penalty

If you do not precertify in advance of certain procedures (listed in this section), or if you choose to ignore Aetna's advice, your benefits may be reimbursed at a lower level and certain penalties will apply:

- For care that otherwise would have been approved had Aetna been notified, your benefits will be subject to a non-precertification penalty each time Aetna is not notified; and
- For care that would not have been approved, no benefit is payable.

None of the penalty charges will be applied toward your annual out-of-pocket maximum.

The ultimate decisions about medical care must be made by you and your physician. Aetna will determine coverage solely for purposes of deciding which goods and services are covered services.

Approval by Aetna does not guarantee that benefits are payable under the Citigroup Inc. Medical Benefits Plan. Benefits are based on:

- The covered services and supplies actually performed or given;
- Your eligibility under the Aetna plan on the date the covered services and supplies are performed or given; and
- Copayments, deductibles, coinsurance, maximum limits, and all other terms of the Aetna plan.

Aetna *must* be notified *before* you receive certain outpatient or diagnostic procedures, as well as any of the services including, but not limited to, those shown in this section. This is not a complete list of all services that require precertification by Aetna. For a complete list, contact Aetna directly.

Inpatient confinements

For inpatient confinement, you must call Aetna for precertification at least 14 days prior to the scheduled admission date. An admission date may not have been set when the confinement was planned. You must call Aetna again as soon as the admission date is set. If you do not obtain precertification, you will be charged a non-precertification penalty of \$500. The penalty will be deducted from your reimbursement under the Aetna plan. It will not apply toward your deductible or out-of-pocket maximum.

You must obtain precertification for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call *within* 48 hours after the admission.

Outpatient surgery/diagnostic testing

If you do not call to precertify certain outpatient services, you will be charged a non-notification penalty of \$200 or the amount of the covered charge, whichever is less. The penalty will be deducted from your reimbursement under your Aetna plan. It will not apply toward your deductible or out-of-pocket maximum.

Please keep in mind that your PCP will handle the precertification process for you when you receive any network services.

If you are enrolled in the Aetna Managed Choice Plan, when you receive care from an out-of-network provider, you must obtain precertification for the following services:

- Bunionectomy — surgical removal of a bunion;
- Carpal tunnel surgery — surgical treatment of carpal tunnel syndrome;
- Colonoscopy — colon exam;
- Coronary angiography — examination of vessels using radiographic imaging technology;
- CT scan of the spine — cross-sectional scan of the spine;
- Diagnostic tests for organ or tissue transplants;
- Dilation and curettage (D&C) — surgical scraping of the uterus;
- Hammertoe repair — interphalangeal fusion, filleting, and/or phalangectomy;
- Hemorrhoidectomy — surgical removal of hemorrhoids;
- Knee arthroscopy — interior examination of the knee joint;
- Laparoscopy (abdominal) — interior examination of the abdomen;
- MRI of the knee — examination of the knee using imaging technology;
- MRI of the spine — examination of the spine using imaging technology;
- Nasal endoscopy — visual examination of the nose by means of an endoscope;
- Rhinoplasty — plastic surgery of the nose;
- Septoplasty — surgery of the nasal wall;
- Tympanostomy tube — insertion of a tube in the middle ear; and
- Upper gastrointestinal endoscopy — interior examination of the stomach and intestines.

For outpatient services that require precertification, you must call Aetna for precertification at least five working days before the service is given.

Mental health/chemical dependency

You must call Aetna for precertification before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify Aetna before the scheduled date of any of the following:

- The evaluation;
- The donor search;

- The organ procurement/tissue harvest; and
- The transplant.

See organ/tissue transplants in **Covered services and supplies** for information about precertification requirements. Aetna will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

- Aetna should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- For the Aetna Managed Choice Plan, you must notify the plan to certify inpatient confinement for delivery of a child. This is to certify a length of stay of:
 - 48 hours following a normal vaginal delivery; or,
 - 96 hours following a cesarean section.
- For inpatient care (for either the mother or child) that continues beyond the ⁴⁸/₉₆ hour limits stated above, Aetna must be notified before the end of these time periods; and
- Non-emergency inpatient confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician do not agree with Aetna's determination, you may appeal the decision. For information about the claims appeal process, see **Claims and appeals for Aetna medical plans**.

CIGNA plans

If you are enrolled in a CIGNA plan, you must call CIGNA to precertify any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Scheduled inpatient services must be precertified at least 14 days in advance. Outpatient procedures must be precertified at least five days in advance. CIGNA must be notified of emergency admissions within 48 hours of the admission.

You are not required to notify the carrier of emergency hospitalization or other emergency services occurring outside the U.S.

Non-precertification penalty

If you do not notify CIGNA in advance of certain procedures (listed in this section), or if you choose to ignore CIGNA's advice, your benefits may be reimbursed at a lower level and certain penalties will apply:

- For care that otherwise would have been approved had CIGNA been notified, your benefits will be subject to a non-precertification penalty each time CIGNA is not notified; and
- For care that would not have been approved, no benefit is payable.

If you are enrolled in a CIGNA plan, you will be responsible for 50% of the excess expense, up to a maximum of \$1,000 per calendar year, each time you fail to call for care that would have been managed differently if you had notified CIGNA (known as "excessive care").

None of the penalty charges will be applied toward your annual out-of-pocket maximum.

The ultimate decisions about medical care must be made by you and your physician. The CIGNA Health Plans will determine coverage solely for purposes of deciding which goods and services are covered services.

Approval by CIGNA does not guarantee that benefits are payable under the Citigroup Inc. Medical Benefits Plan. Benefits are based on:

- The covered services and supplies actually performed or given;
- Your eligibility under the CIGNA plan on the date the covered services and supplies are performed or given; and
- Copayments, deductibles, coinsurance, maximum limits, and all other terms of the CIGNA plan.

CIGNA *must* be notified *before* you receive certain outpatient or diagnostic procedures, as well as any of the services including, but not limited to, those shown in this section. This is not a complete list of all services that require precertification by CIGNA. For a complete list, contact CIGNA directly.

Inpatient confinements

For inpatient confinement, you must call CIGNA for precertification at least 14 days prior to the scheduled admission date. An admission date may not have been set when the confinement was planned. You must call CIGNA again as soon as the admission date is set. If you do not obtain precertification, you will be charged a non-precertification penalty of \$500 or the amount of the covered charge, whichever is less. The penalty will be deducted from your reimbursement under the CIGNA plan. It will not apply toward your deductible or out-of-pocket maximum.

You must obtain precertification for:

- A scheduled hospital admission, including to a mental health or chemical dependency treatment facility;
- A scheduled admission to a skilled-nursing facility or hospice care facility;
- Home health care; and
- Private duty nursing.

In case of an unscheduled or emergency admission, you or your doctor must call *within* 48 hours after the admission.

Outpatient surgery/diagnostic testing

If you do not call to precertify certain outpatient services, you will be charged a non-precertification penalty of \$200 or the amount of the covered charge, whichever is less. The penalty will be deducted from your reimbursement under the CIGNA plan. It will not apply toward your deductible or out-of-pocket maximum.

Please keep in mind that your PCP will handle the precertification process for you when you receive any network services.

For the CIGNA POS plan, when you receive care from an out-of-network provider, you must obtain precertification for the following services:

- Bunionectomy — surgical removal of a bunion;
- Carpal tunnel surgery — surgical treatment of carpal tunnel syndrome;
- Coronary angiography — examination of vessels using radiographic imaging technology;
- CT scan of the spine — cross-sectional scan of the spine;
- Diagnostic tests for organ or tissue transplants;
- Dilation and curettage (D&C) — surgical scraping of the uterus;

- Hammertoe repair — interphalangeal fusion, filleting, and/or phalangectomy;
- Hemorrhoidectomy — surgical removal of hemorrhoids;
- Knee arthroscopy — interior examination of the knee joint;
- Laparoscopy (abdominal) — interior examination of the abdomen;
- MRI of the knee — examination of the knee using imaging technology;
- MRI of the spine — examination of the spine using imaging technology;
- Nasal endoscopy — visual examination of the nose by means of an endoscope;
- Rhinoplasty — plastic surgery of the nose;
- Septoplasty — surgery of the nasal wall;
- Tympanostomy tube — insertion of a tube in the middle ear; and
- Upper gastrointestinal endoscopy — interior examination of the stomach and intestines.

For outpatient services that require precertification, you must call CIGNA for precertification at least five working days before the service is given.

Mental health/chemical dependency

You must call CIGNA for precertification before you obtain covered mental health and/or chemical dependency treatment.

Organ/tissue transplants

You must notify CIGNA before the scheduled date of any of the following:

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant.

See organ/tissue transplants in **Covered services and supplies** for information about precertification requirements. CIGNA will then complete the utilization review. You, the physician, and the facility will receive a letter confirming the results of the utilization review.

Pregnancy

Pregnancy is subject to the following notification time periods:

- CIGNA should be notified during the first trimester (12 weeks) of pregnancy. This early notification makes it possible for the mother to participate in a prenatal program;
- For the CIGNA POS Plan, for inpatient confinement for delivery of child, you must certify a length of stay of:
 - 48 hours following a normal vaginal delivery; or,
 - 96 hours following a cesarean section.

- For inpatient care (for either the mother or child) that continues beyond the $\frac{48}{96}$ hour limits stated above, CIGNA must be notified before the end of these time periods; and
- Non-emergency confinement during pregnancy but before the admission for delivery requires notification as a scheduled confinement.

If you or your physician do not agree with CIGNA's determination, you may appeal the decision. For more information about the claims appeal process, see **Claims and appeals for CIGNA medical plans**.

Covered services and supplies

This list of covered services and supplies applies to all Health Plans sponsored by Citigroup.

Covered services and supplies must be medically necessary and related to the diagnosis or treatment of an accidental injury, sickness, or pregnancy. Reimbursement for all covered services and supplies listed in this section are subject to reasonable and customary (R&C) guidelines, or, for network services, the negotiated rates of the Health Plan.

You and your physician decide which services and supplies are required, but the Health Plans only pay for the following covered services and supplies that are medically necessary as determined by the Claims Administrators.

Covered services and supplies also include services and supplies that are part of a case management program. A case management program is a course of treatment developed by the Claims Administrator as an alternative to the services and supplies that would otherwise have been considered covered services and supplies. Unless the case management program specifies otherwise, the provisions of the Health Plan related to benefit amounts, maximum amounts, copayments, and deductibles will apply to these services.

Acupuncture

Must be administered by a medical doctor or a licensed acupuncturist.

- **UnitedHealthcare EPO:** acupuncture is not covered; and
- **Aetna HMO:** acupuncture is covered only for certain conditions.

Ambulatory surgical center

A center's services given within 72 hours before or after a surgical procedure. The services must be given in connection with the procedure.

Anesthetics

Drugs that produce loss of feeling or sensation either generally or locally.

Baby care

The following services and supplies given during an eligible newborn child's initial hospital confinement:

- Hospital services for nursery care;
- Other services and supplies given by the hospital;
- Services of a surgeon for circumcision in the hospital; and
- Physician services.

Birth center

Room and board and other services, supplies and anesthetics.

Cancer detection

Colonoscopy.

Diagnostic screenings not subject to precertification or notification include:

- Mammogram;
- Pap smear;
- Prostatic-specific antigen (PSA); and
- Sigmoidoscopy.

Chemotherapy

For cancer treatment.

Contraceptive services/devices

Contraceptive services and devices, including but not limited to:

- Diaphragm and intrauterine device and related physician services;
- Voluntary sterilization by either vasectomy or tubal ligation (reversals not covered by **UnitedHealthcare**);
- Injectables such as Depo-Provera; and
- Surgical implants for contraception, such as Norplant.

Dietitian/nutritionist

Nutritional counseling is covered by a licensed dietitian and/or licensed nutritionist for diabetes, bulimia, and anorexia nervosa only.

- **Aetna Managed Choice:** nutritional counseling is not covered if billed directly by a licensed dietitian and/or licensed nutritionist. It is covered for other diagnosis if medically necessary; and
- **UnitedHealthcare EPO:** dietitian and licensed nutritionist services are not covered.

Durable medical equipment

Durable medical equipment means equipment that meets all of the following:

- It is for repeated use and is not a consumable or disposable item;
- It is used primarily for a medical purpose; and
- It is appropriate for use in the home.

Some examples of durable medical equipment are:

- Appliances that replace a lost body organ or part or help an impaired organ or part;
- Orthotic devices such as arm, leg, neck, and back braces;
- Hospital-type beds;
- Equipment needed to increase mobility, such as a wheelchair;

- Respirators or other equipment for the use of oxygen; and
- Monitoring devices (e.g., blood glucose monitor).

Each Health Plan decides whether to cover the purchase or rental of the equipment based on coverage guidelines. Changes made to your home, automobile or personal property are not covered. Rental coverage is limited to the purchase price of the durable medical equipment. Replacement, repair, and maintenance are covered only if:

- They are needed due to a change in your physical condition, or
- It is likely to cost less to buy a replacement than to repair the existing equipment or rent like equipment.

Foot care

Care and treatment of the feet, if needed due to severe systemic disease. Routine care such as removal of warts, corns, or calluses, the cutting and trimming of toenails, foot care for flat feet, fallen arches, and chronic foot strain is a covered service only if needed due to severe systemic disease.

- **Aetna Managed Choice** covers the services of a podiatrist for the treatment of a disease or injury, including the treatment of corns, calluses, keratoses, bunions, and ingrown toenails. Pedicure services, such as routine cutting of nails, are not covered unless there is a disease of the nails.

Hearing aids

Hearing aids required as a result of an accident that occurred while covered under the Health Plans are covered. This hearing aid benefit is limited to one hearing aid per ear every 36 months.

Home health care

The following covered services must be given by a home health care agency:

- Temporary or part-time skilled nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN);
- Temporary or part-time care by a home health aide for skilled care; and
- Medical social services provided by, or supervised by, a qualified physician or social worker if your physician certifies with the plan that the medical social services are necessary for the treatment of your medical condition.

Covered services are limited to 40 visits each calendar year. Each period of home health aide care of up to four hours given in the same day counts as one visit. Each visit by any other member of the home health team will count as one visit. Multiple services provided on the same day count as one visit and are billed by the same provider on the same bill.

For **CIGNA POS**, services may be provided for more than 40 visits if the Claims Administrator, after review of the participant's medical condition, determines that additional visits are necessary, medically appropriate and deems the care necessary to prevent further medical complications.

Hospice care

Hospice services for a participant who is terminally ill include:

- Room and board coverage is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available);
- Other services and supplies;
- Part-time nursing care by or supervised by a registered nurse (RN) or licensed practical nurse (LPN);
- Home health care services as shown under home health care; the limit on the number of visits shown under home health care does not apply to hospice patients;
- Counseling for the patient and covered dependents;
- Pain management and symptom control; and
- Bereavement counseling for covered dependents; services must be given within six months after the patient's death, and covered services are limited to a total of 15 visits for each family member (For **Aetna Managed Choice**, bereavement counseling is covered under the mental health benefit.)

Bereavement counseling must be given by a licensed counselor. Services for the patient must be given in an inpatient hospice facility or in the patient's home. The physician must certify that the patient is terminally ill with six months or less to live. Any counseling services given in connection with a terminal illness will not be considered as mental health and chemical dependency treatment for purposes of applying the mental health/chemical dependency maximum visit limit.

Hospital services

Hospital services include:

- Room and board: covered expenses are limited to the regular daily charge made by the hospital for a semiprivate room (or private room when medically appropriate);
- Other services and supplies, including:
 - Intensive or special care facilities when medically appropriate;
 - Visits by your physician while you are confined;
 - General nursing care;
 - Outpatient private-duty nursing when medically appropriate and certified by a specialist (in agreement with your PCP for the POS and HMO plans). Inpatient private duty nursing is not covered;
 - Surgical, medical, and obstetrical services;
 - Use of operating rooms and related facilities;
 - Medical and surgical dressings, supplies, casts, and splints;
 - Drugs and medications;
 - Intravenous injections and solutions;

- Nuclear medicine;
- Pre-operative care and post-operative care:
 - Administration and processing of blood;
 - Anesthesia and anesthesia services;
 - Oxygen and oxygen therapy;
 - Inpatient physical and rehabilitative therapy, including cardiac and pulmonary rehabilitation;
 - X-rays, laboratory tests, and diagnostic services; and
 - Magnetic resonance imaging (MRI).

Emergency room services are covered services only if it is determined that the services are medically appropriate and there is not a less intensive or more appropriate place of service, diagnostic, or treatment alternative that could have been used in lieu of emergency room services. If your Health Plan, at its discretion, determines that a less intensive or more appropriate treatment could have been given, then no benefits are payable.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, to discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

Infertility treatment

Infertility benefits are provided only through the following medical options managed by UnitedHealthcare: Select Plus POS plan, Health Plan 2000, Health Plan 200 (Hawaii only), or, where no POS plan is available, the Out-of-Area Plan.

Diagnosis of infertility and surgical correction of a medical condition causing infertility are covered subject to the Health Plan's copayment or deductible and coinsurance. Treatment for infertility requires a documented two-year history of infertility or a medical condition that, either through surgery or other procedure, would not reverse the infertility regardless of the two-year history.

Covered services include:

- Services for diagnosis and treatment of the underlying medical condition:
 - Initial evaluation, including history, physical exam, and laboratory studies;
 - Evaluation of ovulation function;
 - Ultrasound of ovaries;
 - Post-coital test;
 - Hysterosalpingogram;
 - Endometrial biopsy;

- Hysteroscopy; and
- Semen analysis for male members.
- Advanced Reproductive Services:
 - Ovulation induction cycle with menotropins
 - Artificial insemination
 - Infertility surgery (diagnostic or therapeutic);
 - ART services and treatment, including in vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transfer (ZIFT), and cryopreserved embryo transfer and Frozen Embryo Transfer (FET);

Storage of frozen sperm or embryos is not covered.

- Medical expenses are covered up to a maximum of \$8,000 a year, with a lifetime maximum of \$24,000.
- Prescription drug expenses associated with infertility treatment are covered up to a maximum of \$2,500 a year, with a lifetime maximum of \$7,500, through the **Prescription drug program**.

The Aetna Managed Choice and CIGNA POS plans cover only the diagnosis and treatment of underlying causes of infertility and do not cover medical infertility treatment. However, they do provide coverage for infertility prescription drugs through the **Prescription drug program**.

HMOs may offer different infertility coverage. Check with your HMO for specific details of infertility coverage.

Laboratory tests/x-rays

X-rays or tests for diagnosis or treatment.

Licensed counselor services

Services of a licensed counselor for mental health and chemical dependency treatment.

Medical care

- Hospital, office, and home visits; and
- Emergency room services.

Medical supplies

- Surgical supplies (such as bandages and dressings). Supplies given during surgery or a diagnostic procedure are included in the overall cost for that surgery or diagnostic procedure; and
- Blood or blood derivatives only if not donated or replaced. This means:
 - Autologous blood donation — the donation of your own blood for use during a scheduled covered surgical procedure;

- Directed blood donation — the donation of blood by a person chosen by the patient to donate blood for the patient’s use during a scheduled covered surgical procedure; and
- Autologous or directed blood donation prior to a scheduled surgery when it generally requires blood transfusions and the provider/organization that obtains and processes the blood makes a charge the patient is legally obligated to pay.

Medical transportation services

Transportation by professional ambulance or air ambulance to and from the nearest medical facility qualified to give the required treatment. These services must be given within the United States, Puerto Rico, or Canada. (**Aetna Managed Choice** covers medical transportation services outside of these geographic areas.)

The Health Plans cover professional ambulance service on a standard basis to transport the individual from the place where he/she is injured or stricken by disease to the first hospital where treatment is given. Ambulette is not covered.

Nurse-midwife

Services of a licensed or certified nurse-midwife. Maternity-related benefits are payable on the same basis as services given by a physician.

Nurse-practitioner

Services of a licensed or certified nurse-practitioner acting within the scope of that license or certification. Benefits are payable on the same basis as covered services given by a physician.

Oral surgery/dental services

The Health Plans pay first (the primary plan) for the following services:

- Oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition;
- The following services and supplies are covered only if needed because of accidental injury to sound and natural teeth that happened to you or your dependent while covered under this Plan:
 - Oral surgery;
 - Full or partial dentures;
 - Fixed bridgework;
 - Prompt repair to sound and natural teeth; and
 - Crowns.

Organ/tissue transplants

Your Health Plan must be notified at least seven business days before the scheduled date of any of the following (or as soon as reasonably possible):

- The evaluation;
- The donor search;
- The organ procurement/tissue harvest; and
- The transplant procedure.

Donor charges for organ/tissue transplants

- In the case of an organ or tissue transplant, donor charges are considered covered expenses *only* if the recipient is a covered person under the Health Plan. If the recipient is not a covered person, no benefits are payable for donor charges.
- The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a covered service *unless* the search is made in connection with a transplant procedure arranged by a designated transplant facility.

Qualified procedures

If a qualified procedure, listed in this section, is medically necessary and performed at a designated transplant facility, the “medical care and treatment” and “transportation and lodging” provisions described in this section apply.

- Heart transplants;
- Lung transplants;
- Heart/lung transplants;
- Liver transplants;
- Kidney transplants;
- Pancreas transplants;
- Kidney/pancreas transplants;
- Bone marrow/stem cell transplants; and
- Other transplant procedures when your Health Plan determines that they are medically necessary to perform the procedure as a designated transplant.

For **Aetna**, transplant services are covered as long as the transplant is not experimental or investigational and has been approved in advance. Transplants must be performed in hospitals specifically approved and designated by Aetna to perform the procedure. The Institutes of Excellence (IOE) network is Aetna’s network of providers for transplants and transplant-related services, including evaluations and follow-up care. Each facility has been selected to perform only certain types of transplants, based on their quality of care and successful clinical outcomes. Under the Managed Choice Plan, a transplant will be covered as In-Network care only if performed in a facility that has been designated as an IOE facility for the type of transplant in question. Any facility that is not specified as an Institute of Excellence network facility is considered a non-participating facility for transplant-related services, even if the facility is considered a participating facility for other types of services.

For **CIGNA POS** and **the Cigna HMO**, network services are rendered at participating LIFESOURCE facilities. If you participate in the POS Plan and select a non-LIFESOURCE facility for transplant and treatment, your care will be covered at the out-of-network level.

For **UnitedHealthcare**, United Resource Networks (URN) will coordinate your transplant activity. When an URN facility is used, benefits will be paid at the network level. When you use a non-URN network facility, benefits will be paid at the network level without access to the travel and lodging benefit. When a non-network facility is used, benefits will be paid at the non-network level without access to the travel and lodging benefit.

Medical care and treatment

The covered expenses for services provided in connection with the transplant procedure include:

- Pre-transplant evaluation for one of the procedures listed above;
- Organ acquisition and procurement;
- Hospital and physician fees;
- Transplant procedures;
- Follow-up care for a period of up to one year after the transplant; and
- Search for bone marrow/stem cell from a donor who is not biologically related to the patient. If a separate charge is made for bone marrow/stem cell search, a maximum benefit of \$25,000 is payable for all charges made in connection with the search. (This maximum does not apply to the **Aetna** or **CIGNA HealthCare plans**.)

Transportation and lodging

When available, the Health Plan will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging, and meals for the transplant recipient and a companion are available as follows:

- Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion. Benefits are paid at per diem rate of \$50 for one person or \$100 a day for two people. (For **Aetna plans**, a maximum of \$50 per person – \$100 for patient and companion combined — per night is paid towards lodging expenses. Meals are not covered.);
- Travel and lodging expenses are available only if the transplant recipient resides more than:
 - 50 miles from the designated transplant facility for **UnitedHealthcare** plans
 - 100 miles from the designated transplant facility for **Aetna** plans
 - 60 miles from the designated transplant facility for **CIGNA** plans;
- If the patient is a covered dependent minor child, the transportation expenses of two companions (one companion for **Aetna plans**; both parents for **CIGNA HealthCare plans**) will be covered, and lodging and meal expenses will be reimbursed at the \$100 per diem rate;
- There is a combined overall lifetime maximum of \$10,000 per covered person for all transportation, lodging, and meal expenses incurred by the transplant recipient and companion and reimbursed under the Health Plan in connection with all transplant procedures. (For **Aetna plans**, a \$10,000 maximum will apply to all non-health benefits in connection with any one type of procedure. These benefits are available until one year following the date of the procedure.)

If the covered person chooses not to receive his or her care in connection with a qualified procedure pursuant to this organ/tissue transplant section, the services and supplies received by the covered person in connection with that qualified procedure will be paid under the Health Plan if and to the extent covered by the Health Plan without regard to this organ/tissue transplant section.

There may be some differences in coverage for transportation and lodging. **CIGNA plans** only cover transportation and lodging when a member uses a LIFESOURCE facility. For **UnitedHealthcare**, United Resource Networks (URN) will coordinate your transplant activity. When an URN facility is used, benefits will be paid at the network level. When you use a non-URN facility, benefits will be paid at the network level without access to the travel and lodging benefit.

For more information, contact your Health Plan directly.

Orthoptic training

Training by a licensed optometrist or an orthoptic technician. The Health Plans cover a hidden ocular muscle condition where the eyes have a tendency to underconverge or overconverge. Manifest conditions of exotropia (turning out) or esotropia (turning in) are covered. Coverage is limited to 32 visits per calendar year. Care is reimbursed at 100% after you pay the copayment or at the out-of-network level if network coverage is available and you use an out-of-network provider.

Outpatient occupational therapy

See rehabilitation therapy.

Outpatient physical therapy

See rehabilitation therapy.

Preferred brand-name drug

A drug that is prescribed from a list of medications preferred for its 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 call formulary drugs.

Prescribed drugs

Prescribed drugs and medicines for inpatient services.

Private-duty nursing care

Private-duty nursing care given on an outpatient basis by a licensed nurse (RN, LPN, or LVN). This service must be approved by your Health Plan.

- **Aetna Managed Choice and UnitedHealthcare Select Plus:** there is a combined network and out-of-network maximum benefit of 120 visits per calendar year
- **CIGNA POS:** there is a maximum benefit of 40 visits per calendar year for out-of-network services.
- **UnitedHealthcare:** you must notify the Health Plan before beginning outpatient private-duty nursing care. Inpatient private-duty nursing is not covered. Services may be provided for more than 120 visits if the Claims Administrator, after review of the patient's medical condition, determines that additional visits are necessary and medically appropriate.

Psychologist services

Services of a psychologist for psychological testing and psychotherapy.

Radiation Therapy

Rehabilitation Therapy

Defined as short-term occupational therapy, physical therapy, speech therapy, and spinal manipulation:

- Services of a licensed occupational or physical therapist, provided the following conditions are met:
 - The therapy must be ordered and monitored by a licensed physician;
 - The therapy must be given according to a written treatment plan approved by a licensed physician. The therapist must submit progress reports at the intervals stated in the treatment plan; and
 - The therapy must be for treatment of non-chronic conditions and acute illness or injury.
- Services of a licensed speech therapist. These services must be given to restore speech lost or impaired due to one of the following:
 - Surgery, radiation therapy, or other treatment that affects the vocal chords;
 - Cerebral thrombosis (cerebral vascular accident);
 - Brain damage due to accidental injury or organic brain lesion (aphasia); or
 - Accidental injury that happens while the person is covered under the Health Plan.

Inpatient

- Services of a hospital or rehabilitation facility for room, board, care, and treatment during a confinement. Coverage for room and board is limited to expenses for the regular daily charge made by the hospital for a semi-private room (or private room when medically appropriate or if it is the only room type available)
- Inpatient rehabilitative therapy is a covered service only if intensive and multidisciplinary rehabilitation care is necessary to improve the patient's ability to function independently. (For **UnitedHealthcare plans**, inpatient rehabilitation facility services and skilled nursing facility services are subject to a combined maximum of 120 days per year.)

Outpatient

- Services of a hospital, comprehensive outpatient rehabilitative facility (CORF), or licensed therapist as described above;
- Coverage includes short-term cardiac rehabilitation following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction;
- Coverage includes short-term pulmonary rehabilitation for the treatment of reversible pulmonary disease;
- All visit limits apply for both network and out-of-network, wherever the services are being provided, for example, at home, at a therapist's office, or in a free-standing therapy facility;
- **POS Plans:** Chiropractic therapy limited to 20 visits per calendar year. All other therapies combined are limited to 60 visits per calendar year for restorative care, with a separate chronic/developmental delay benefit of 24 visits per calendar year;
- **Health Plan 2000, Health Plan 200 and Out-of-Area plan:** maximum of 20 visits of each type of therapy each calendar year for restorative care, with a separate chronic/developmental delay benefit of 24 visits per calendar year;

- **UnitedHealthcare EPO:** maximum of 20 visits of each type of therapy each calendar year; and
- **Aetna and CIGNA HealthCare HMO:** maximum of 60 visits for all types of therapy combined each calendar year.

Skilled nursing facility services

- Room and board: covered expenses for room and board are limited to the facility's regular daily charge for a semi-private room
- Other services and supplies.

Covered services are limited to the first 120 days of confinement each calendar year. (For **CIGNA HealthCare** and **UnitedHealthcare**, this is a combined limit with inpatient rehabilitation facility services.)

Speech therapy

See rehabilitation therapy.

Spinal manipulations

Services of a physician given for the detection or correction (manipulation) by manual or mechanical means or structural imbalance or distortion of the spine. Routine maintenance and adjustments are not a covered service under this Plan. See **Rehabilitation Therapy** for limits on the number of visits covered.

Surgery

Services for surgical procedures. Under the HMO plans, all surgical procedures must be approved in advance.

Reconstructive surgery

- Reconstructive surgery to improve the function of a body part when the malfunction is the direct result of one of the following:
 - Birth defect;
 - Sickness;
 - Surgery to treat a sickness or accidental injury;
 - Accidental injury that happens while the person is covered under the Health Plan;
- Reconstructive breast surgery following a mastectomy including areolar reconstruction and the insertion of a breast implant. The Health Plan covers expenses associated with reconstructive surgery following a mastectomy, expenses for reconstructive surgery on the other breast to achieve symmetry, the cost of prostheses and the cost for treatment of physical complications at any stage of the mastectomy including lymphedemas. Normal Plan deductibles, coinsurance and copayments will apply; and
- Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to sickness or accidental injury that happens while the person is covered under the Health Plan.

Assistant surgeon services

Covered expenses for assistant surgeon services are limited to 20% (25% for **Aetna Managed Choice**) of the amount of covered expenses for the primary surgeon's charge for the surgery for non-HMO plans. An assistant surgeon generally must be a licensed physician. Physician's assistant services are not covered if billed on their own behalf. Under the HMO plans, these services are covered in full, provided a participating surgeon is used. (**Aetna** and UnitedHealthcare cover assistant surgeon services for certain surgeries. **Aetna** covers registered nurses acting as assistant surgeons.)

Multiple surgical procedures

Multiple surgical procedures means more than one surgical procedure performed during the same surgical session. Covered expenses for multiple surgical procedures are subject to the Health Plan review.

Termination of pregnancy

- Voluntary (i.e., abortion); and
- Involuntary (i.e., miscarriage).

Treatment centers

- Room and board; and
- Other services and supplies.

Voluntary sterilization

- Vasectomy; and
- Tubal ligation.
- Reversals are not covered.

Well-child care

Office visit charges for routine well-child care examinations and immunizations, based on guidelines from the American Medical Association and physician recommendations.

Wellness benefit

Covered expenses include:

- Routine physical examination (including well-woman exams);
- Immunizations;
- Vision examination;
- Smoking cessation (not covered under the UnitedHealthcare EPO);
- Weight control (not covered by Aetna); and
- Stress management (not covered by Aetna and CIGNA HealthCare).

There is a \$250 calendar year maximum that applies per covered family member. This maximum does not apply to wellness visits to POS or HMO network providers, for well-child care and immunizations, or for routine care under Health Plan 200.

Women's Health and Cancer Rights Act of 1998

Your group health plan benefits described in this SPD provide benefits for mastectomy-related services, and the complications resulting from a mastectomy (including lymphedema), as required by the Women's Health and Cancer Rights Act of 1998. These benefits include reconstruction and surgery to achieve breast symmetry, and prostheses. For more information, please refer to **Surgery** and your medical insurance carrier booklet. Normal plan deductibles and coinsurance may apply.

For information on what is not covered, see **Exclusions and limitations**.

Exclusions and limitations

There are services and expenses that are not covered under the Health Plans. The following list of exclusions and limitations applies to all Health Plans sponsored by Citigroup:

- Acupuncture and acupuncture therapy, except as listed in **Covered services and supplies**;
- Ambulance services, when used as routine transportation to receive inpatient or outpatient services;
- Any service in connection with, or required by, a procedure or benefit not covered by the Health Plans;
- Any services or supplies that are not medically necessary, as determined by the Health Plans;
- Beam neurologic testing;
- Biofeedback, except as specifically approved by the Health Plans;
- Blood, blood plasma, or other blood derivatives or substitutes, except as listed in **Covered services and supplies**;
- Breast augmentation and otoplasties, including treatment of gynecomastia. Reduction mammoplasty is not covered unless medically appropriate, as determined by the Health Plans;
- Charges for canceled office visits or missed appointments;
- Care for conditions that, by state or local law, must be treated in a public facility, including mental illness commitments;
- Care furnished to provide a safe surrounding, including the charges for providing a surrounding free from exposure that can worsen the disease or injury;
- Charges made by a hospital for confinement in a special area of the hospital that provides non-acute care, by whatever name called, including, but not limited to, the type of care given by the facilities listed below:
 - Adult or child day care center;
 - Ambulatory surgical center;
 - Birth center;
 - Halfway house;
 - Hospice;
 - Skilled nursing facility;
 - Treatment center;
 - Vocational rehabilitation center; and
 - Any other area of a hospital that renders services on an inpatient basis for other than acute care of sick, injured, or pregnant persons. If that type of facility is otherwise covered under the Health Plans, then benefits for that covered facility, which is part of a hospital, as defined, are payable at the coverage level for that facility, not at the coverage level for a hospital;

- Cosmetic surgery or surgical procedures primarily for the purpose of changing the appearance of any part of the body to improve appearance or self-esteem. Cosmetic procedures including, but not limited to, pharmacological regimens, nutritional procedures or treatments, plastic surgery, salabrasion, chemosurgery and other such skin abrasion procedures associated with the removal of scars, tattoos, actinic changes, and/or which are performed as a treatment for acne. However, the Health Plans cover reconstructive surgery, as outlined in **Covered services and supplies**;
- Court-ordered services and services required by court order as a condition of parole or probation, unless medically appropriate and provided by participating providers upon referral from your PCP (no referral required for UnitedHealthcare);
- Coverage for an otherwise eligible person or a dependent who is on active military duty, including health services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country;
- Custodial care made up of services and supplies that meets one of the following conditions:
 - Care furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide medical treatment;
 - Care that can safely and adequately be provided by persons who do not have the technical skills of a health care professional;
- Care that meets one of the above conditions is custodial care regardless of any of the following:
 - Who recommends, provides, or directs the care;
 - Where the care is provided; and
 - Whether or not the patient or another caregiver can be or is being trained to care for himself or herself;
- Dental care or treatment to the mouth, teeth, gums, or supporting structures such as, but not limited to, periodontal treatment, endodontic services, extractions, implants, or any treatment to improve the ability to chew or speak. See **Covered services and supplies** for limited coverage of oral surgery and dental services;
- Devices used specifically as safety items or to affect performance primarily in sports-related activities; all expenses related to physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation;
- Ecological or environmental medicine, diagnosis, and/or treatment;
- Educational services, special education, remedial education, or job training. The Health Plans do not cover evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental and learning disorders, behavioral training, or cognitive rehabilitation. Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities, and developmental delays are not covered by the Health Plans;
- Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged, or a nursing home;
- Enteral feedings and other nutritional and electrolyte supplements, unless it is the sole source of sustenance;
- Expenses that are the legal responsibility of a third-party payer, such as Workers' Compensation or as a result of an automobile claim;

- Expenses incurred by a dependent if the dependent is covered as an employee for the same services under the Health Plan;
- Experimental, investigational, or unproven services and procedures; ineffective surgical, medical, psychiatric, or dental treatments or procedures; research studies; or other experimental or investigational health care procedures or pharmacological regimes, as determined by the Health Plans, unless approved by the Health Plans in advance. This exclusion will not apply to drugs:
 - That have been granted investigational new drug (IND) treatment or Group c/treatment IND status;
 - That are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute;
 - That the Health Plans have determined, based upon scientific evidence, demonstrate effectiveness or show promise of being effective for the disease. Refer to the v for a definition of experimental, investigational or unproven services;
- Eyeglasses, contact lenses, and hearing aids unless required due to an accidental injury that happens while covered under the Health Plans (this hearing aid benefit is limited to one hearing aid per ear every 36 months);
- False teeth;
- Hair analysis;
- Hair transplants, hair weaving or any drug used in connection with baldness. Wigs and hairpieces are not covered unless the hair loss is due to chemotherapy or radiation therapy. Wigs and hairpieces needed for endocrine, metabolic diseases, psychological disorders (such as stress or depression), burns, or acute traumatic scalp injury associated with hair loss must be evaluated and pre-authorized by the Health Plans;
- Health services, including those related to pregnancy, that are provided before your coverage is effective or after your coverage has been terminated;
- Herbal medicine, holistic, or homeopathic care, including drugs;
- Household equipment, including (but not limited to) the purchase or rental of exercise cycles, air purifiers, central or unit air conditioners, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, are not covered. Improvements to your home or place of work, including (but not limited to) ramps, elevators, handrails, stair glides, and swimming pools, are not covered;
- Hypnotherapy, except when approved in advance by the Health Plans;
- Immunizations related to travel or work (covered by **Aetna**);
- Implantable drugs (other than contraceptive implants);
- Infertility services, except as described under **Covered services and supplies**. The Health Plans do not cover charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm, and donor costs, including (but not limited to) the cost of donor eggs and donor sperm, the costs for ovulation predictor kits, and the costs for donor egg programs or gestational carriers;
- Inpatient private duty or special nursing care. Outpatient private duty nursing services must be pre-authorized by the Health Plans (**UnitedHealthcare** must receive notification in advance.);
- Membership costs for health clubs, personal trainers, massages, weight loss clinics, and similar programs;

- Naturopathy;
- Nutritional counseling and nutritionists except as shown in **Covered services and supplies**.
- Occupational injury or sickness. An occupational injury or sickness is an injury or sickness that is covered under a Workers' Compensation act or similar law. For persons for whom coverage under a Workers' Compensation act or similar law is optional because they could elect it, or could have it elected for them, occupational injury or sickness includes any injury or sickness that would have been covered under the Workers' Compensation act or similar law had that coverage been elected;
- Outpatient supplies, including (but not limited to) outpatient medical consumable or disposable supplies such as syringes, incontinence pads, elastic stockings, and reagent strips;
- Personal comfort or convenience items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, barber services, telephone charges, radio and television rentals, homemaker services, travel expenses, take-home supplies, and other similar items and services;
- Physical, psychiatric, or psychological examinations, testing, vaccinations, immunizations or treatments not otherwise covered, when such services are:
 - for purposes of obtaining, maintaining, or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage, or adoption;
 - relating to judicial or administrative proceedings or orders;
 - conducted for purposes of medical research; or
 - to obtain or maintain a license of any type;
- Radial keratotomy or any other related procedures designed to surgically correct refractive errors, such as LASIK, PRK, or ALK;
- Recreational, educational, and sleep therapy, including any related diagnostic testing;
- Religious, marital, and sex counseling, including related services and treatment;
- Reversal of voluntary sterilizations, including related follow-up care;
- Routine hand and foot care services, including routine reduction of nails, calluses, and corn;
- Services not covered by the Health Plans, even when your PCP (for the POS and HMO plans) has issued a referral for those services;
- Services or supplies covered by any automobile insurance policy, up to the policy's amount of coverage limitation;
- Services provided by your close relative (your spouse, child, brother, sister, or the parent or grandparent of you or your spouse) for which, in the absence of coverage, no charge would be made;
- Services given by volunteers or persons who do not normally charge for their services;
- Services required by a third party, including (but not limited to) physical examinations, diagnostic services and immunizations in connection with:
 - Obtaining or continuing employment;
 - Obtaining or maintaining any license issued by a municipality, state, or federal government;

- Securing insurance coverage;
- Travel; and
- School admissions or attendance, including examinations required to participate in athletics unless the service is considered to be part of an appropriate schedule of wellness services;
- Services you are not legally obligated to pay for in the absence of this coverage;
- Services for, or related to, the removal of an organ or tissue from a person for transplantation into another person, unless the transplant recipient is a covered person under the Health Plan and is undergoing a covered transplant. Services for, or related to, transplants involving mechanical or animal organs are not covered;
- Special education, including lessons in sign language to instruct a Health Plan participant whose ability to speak has been lost or impaired to function without that ability;
- Special medical reports, including those not directly related to the medical treatment of a Health Plan participant (such as employment or insurance physicals) and reports prepared in connection with litigation;
- Specific non-standard allergy services and supplies, including (but not limited to):
 - Skin titration (wrinkle method);
 - Cytotoxicity testing (Bryan's Test);
 - Treatment of non-specific candida sensitivity;
 - Urine autoinjections;
- Stand-by services required by a physician;
- Surgical operations, procedures, or treatment of obesity, except when approved in advance by the Health Plans;
- Telephone consultations;
- Therapy or rehabilitation, including (but not limited to):
 - Primal therapy;
 - Chelation therapy (except to treat heavy metal poisoning);
 - Rolfing;
 - Psychodrama;
 - Megavitamin therapy;
 - Purging;
 - Bioenergetic therapy;
 - Vision perception training;
 - Carbon dioxide therapy;
- Thermograms and thermography;

- Transsexual surgery, sex change, or transformation. The Health Plans do not cover any procedure, treatment or related service designed to alter a participant's physical characteristics from his or her biologically determined sex to those of another sex, regardless of any diagnosis of gender role or psychosexual orientation problems;
- Treatment in a federal, state, or governmental facility, including care and treatment provided in a non-participating hospital owned or operated by any federal, state or other governmental entity, except to the extent required by applicable laws;
- Treatment of injuries sustained while committing a felony, assault, or during a riot or insurrection;
- Treatment of developmental delay. This exclusion does not apply to mental health services or medical treatment of the retarded individual as described under **Covered services and supplies**;
- Treatment of diseases, injuries, or disabilities related to military service for which you are entitled to receive treatment at government facilities that are reasonably available to you;
- Treatment, including therapy, supplies, and counseling, for sexual dysfunctions or inadequacies that do not have a physiological or organic basis;
- Treatment of spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion, or dislocation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of, or related to, distortion, misalignment, or dislocation of or in the vertebral column;
- Treatment of temporomandibular joint (TMJ) syndrome, including treatment performed by prosthesis placed directly on the teeth (For **UnitedHealthcare**, bone-related services are covered);
- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans, or any related products.

Glossary

The following definitions apply to all Health Plans sponsored by Citigroup Inc. 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 specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
- Where licensing is not required, it meets all of the following requirements:
 - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who devotes full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
 - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
 - It provides at least one operating room and at least one postanesthesia recovery room;
 - It is equipped to perform diagnostic x-ray and laboratory examinations or has arranged to obtain these services;
 - It has trained personnel and necessary equipment to handle emergency situations;
 - It has immediate access to a blood bank or blood supplies;
 - It provides the full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the postanesthesia recovery room; and
 - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center for the purposes of the Health Plans.

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

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; and
- It meets all of the following requirements:
 - It is operated and equipped in accordance with any applicable state law;
 - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;

- It has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
- It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN);
- It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
- It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary; and
- It 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 Health Plans.

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.

Chiropractic care. Skeletal adjustments, manipulation, or other treatment 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 to be 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, CIGNA HealthCare, UnitedHealthcare, and Medco Health Solutions, Inc. The Claims Administrator does not insure the benefits described in this summary.

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:

- It is approved by Medicare as a comprehensive outpatient rehabilitation facility; or
- It meets all of the following tests:
 - It 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;
 - It 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 provides for the carrying out of such policies by a full- or part-time physician;

- It has a requirement that every patient must be under the care of a physician;
- It is established and operates in accordance with the applicable licensing and other laws.

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

Covered expenses. Those expenses listed under **Covered services and supplies**.

Covered family members or covered person. The employee and the employee's legal spouse and/or dependent children, or qualified domestic partner who are covered under the Health Plans.

Custodial care. The care (including room and board needed to provide that care) given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of custodial care are help in walking and getting out of bed, assistance in bathing, dressing, and feeding, or supervision over medication that normally could be self-administered.

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

Emergency care. Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy;
- Bodily function would be seriously impaired; and
- There would be serious dysfunction of a bodily organ or part.

Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

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

Experimental, investigational, or unproven services. Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Health 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 Pharmacopoeia 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 the 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 which its use is proposed.

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

- Is proved 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 Health Plan or the disposition of its assets, renders investment advice to the Health Plan, or has discretionary authority or responsibility in the administration of the Health Plan.

A fiduciary must carry out his or her duties and responsibilities for providing benefits to the employees and his or her dependent(s) and defraying reasonable expenses of administering the Health Plan. These are duties that must be carried out with care, skill, prudence, and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation, in accordance with the Health Plan documents to the extent that they agree with ERISA.

A “named fiduciary” is the one named in the Health Plan who can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Health Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Health Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment of the procedures; or
- The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

Generic drug. Equivalent medications that contains the same active ingredient 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.

The Health Plan or this Health Plan. The Citigroup Inc. Medical Benefits Plan described in this SPD.

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 of 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 registered nurse (RN) or it has nursing care by a registered nurse (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 the following criteria:
 - It provides 24-hour-a-day, seven-day-a-week service;
 - It is under the direct supervision of a duly qualified physician;
 - It has a nurse coordinator who is a registered nurse 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 the purposes of the Health Plan.

Hospital. An institution engaged primarily in providing medical care 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 of the following tests:
 - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured person by or under the supervision of a staff of duly qualified physicians;
 - It continuously provides, on the premises, 24-hour-a-day nursing service by or under the supervision of registered graduate nurses; and
 - It is operated continuously with organized facilities for operative surgery on the premises.

Injury. An accidental physical injury 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 life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (RN) in continuous and constant attendance 24 hours a day.

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 Health Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which you and your eligible dependent are covered under the Health Plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

Medically necessary or medical necessity. Health care services and supplies that are determined by the Health Plan 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 Health 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 the Health Plan;
- With regard to a person who is 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;
- It must not be primarily scholastic, vocational training, educational or developmental in nature, or experimental or investigational;
- 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, or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this summary 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 the Health Plans.

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 where 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 is 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.

Network pharmacy. Registered and licensed pharmacies, including mail-order pharmacies that participate in the network.

Network provider. A provider that participates in a Point-of-Service (POS) Plan or a Health Plan network, or one of the HMOs.

Nonoccupational 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 to be nonoccupational regardless of 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.

Nonoccupational 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.

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:

- A person licensed by a board of nursing as a registered nurse; and
- A person who 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:

- A person licensed by a board of nursing as a registered nurse; and
- A person who 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 a POS plan or Health Plan network, or an HMO.

Out-of-network pharmacy. A pharmacy other than a Medco network pharmacy.

Out-of-network provider. A provider that does not participate in a POS plan or Health Plan network, or an HMO.

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, laboratory or 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 Chiropractic (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 the POS plans, Health Plan 2000, and the Out-of-Area plan.

Plan Administrator. The Plans Administration Committee of Citigroup Inc.

Plan year. The calendar year beginning on either the effective date of the plan or on the day following the end of the first plan year, which is a short plan year.

Preadmission tests. Tests performed on a covered person in a hospital before confinement as a resident inpatient provided they meet all of 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 its 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 doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs. This is any medicinal substance 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 as the coordinator of member care. The PCP is not an agent or employee of the Claims Administrator or employer.

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:

- A person licensed or certified as a psychologist; or
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Reasonable and customary charge (R&C). Any charge that, for services rendered by or on behalf of a network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

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

Room and board. Room, board, general-duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of 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. Citigroup assumes the risk for all claims and pays them from its general assets. Citigroup has contracted with the Claims Administrators through an administrative services only contract for the Claims Administrators to provide all administration including claims processing associated with the Citigroup Plans.

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. A facility, if approved by Medicare as a skilled nursing facility, is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed physician or registered nurse (RN) who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24-hour-a-day 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 or 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 Health Plan.

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

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a physician and the Administrator;
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;
- It provides at least the following basic services:
 - Room and board (if 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 a hospital are covered as a hospital and not as a treatment center.

Utilization review.

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