Retiree Medical Coverage
Open Choice PPO Retiree Plan
January 1, 2014
January 1, 2010

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Introduction

This SPD describes the following retiree medical plans, as of January 1, 2010:

- Open Choice Preferred Provider Organization (PPO) plan;

The Open Choice Preferred Provider Organization Plan SPD should be read in combination with About Your Retiree Health Care Benefits for more 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 this 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 is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of continuing retiree benefits between Citigroup and any individual. Citigroup reserves the right to amend, terminate or otherwise change the coverage provided to retirees at any time, including after retirement has occurred.
Preferred Provider Organization plan

Under a PPO plan, you have the freedom to choose your doctor or healthcare facility when you need healthcare. How that care is covered and how much you pay for your care out of your own pocket depends on whether the expense is covered by the plan and whether you choose a preferred provider or a non-preferred provider. 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 using preferred providers.

Citigroup offers one PPO plan to eligible retirees and their eligible dependents, the Open Choice PPO. You may find preferred providers by visiting Aetna’s Web site — www.aetna.com — and clicking on DocFind. This will take you to the online provider directory. A list of preferred providers will also be distributed without charge by contacting the Claims Administrator.

Eligibility

You may be eligible to enroll in the Open Choice PPO plan if you retired from Citibank NA and participating companies before 1/1/2004 and were at least age 55 with 5 years of service at the time you retired from the company.

Contact the Benefits Service Center at 1-800-881-3938 if you have questions regarding your medical plan options.

Open Choice PPO

<table>
<thead>
<tr>
<th>Type of service</th>
<th>Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$100</td>
<td>1% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $1,250</td>
</tr>
<tr>
<td>Maximum per family</td>
<td>$200</td>
<td>2% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $2,500</td>
</tr>
</tbody>
</table>

Annual out-of-pocket maximum (includes deductible)
<table>
<thead>
<tr>
<th>Type of service</th>
<th>Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>2% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $2,500</td>
<td>4% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $5,000</td>
</tr>
<tr>
<td>Maximum per family</td>
<td>2.5% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $3,125</td>
<td>5% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $6,250</td>
</tr>
<tr>
<td>Lifetime maximum</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Professional care (in office)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PCP visits (Internists, Family Practitioners, General Practitioners &amp; Pediatricians)</td>
<td>90% after Deductible</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Specialist visits</td>
<td>90% after Deductible</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Allergy treatment</td>
<td>Included in Routine Exam Benefit (Subject to the $250 exam maximum)</td>
<td>Included in Routine Exam Benefit (Subject to the $250 exam maximum)</td>
</tr>
<tr>
<td>Routine care (subject to frequency limits)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well adult</td>
<td>100% no deductible, up to $250, then covered at 90%; immunizations and cancer screenings covered at 100%</td>
<td>100% no deductible, up to $250, then covered at 80% of R&amp;C;</td>
</tr>
<tr>
<td>Well child (including immunizations)</td>
<td></td>
<td>Immunizations covered at 80% of R&amp;C, no deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cancer screenings covered at 100% no deductible up to $250 max then covered at 80% of R&amp;C</td>
</tr>
<tr>
<td>Type of service</td>
<td>Network</td>
<td>Out-of-network</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>The $250 annual credit per person applies to all wellness services in and out of network combined; cancer screenings are Pap smear, mammography, sigmoidoscopy, colonoscopy, and PSA screening</strong></td>
<td><strong>90% after deductible, limited to one exam every 24 months for specialists such as Optometrist or Ophthalmologist</strong></td>
<td><strong>100% no deductible, up to $250, then covered at 80% of R&amp;C;</strong></td>
</tr>
<tr>
<td><strong>Routine vision exams</strong></td>
<td><strong>90% after deductible, limited to one exam every 24 months for specialists such as Optometrist or Ophthalmologist</strong></td>
<td><strong>80% of R&amp;C after deductible</strong></td>
</tr>
<tr>
<td><strong>Routine hearing exams</strong></td>
<td><strong>90% after deductible, limited to one exam every 24 months for specialists such as Audiologist or Otolaryngologist months</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital inpatient and outpatient</strong></td>
<td><strong>90% after deductible; precertification required for hospitalization and certain outpatient procedures</strong></td>
<td><strong>80% of R&amp;C after deductible; precertification required for hospitalization and certain outpatient procedures</strong></td>
</tr>
<tr>
<td><strong>Semi-private room and board, doctor’s charges, lab, x-ray, and surgical care</strong></td>
<td><strong>90% after deductible; precertification required for hospitalization and certain outpatient procedures</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td><strong>Physician office visit</strong></td>
<td><strong>Hospital delivery</strong></td>
</tr>
<tr>
<td><strong>90% after deductible</strong></td>
<td><strong>90% after deductible</strong></td>
<td><strong>80% of R&amp;C after deductible</strong></td>
</tr>
<tr>
<td><strong>Hospital delivery</strong></td>
<td><strong>90% after deductible</strong></td>
<td><strong>80% of R&amp;C after deductible</strong></td>
</tr>
<tr>
<td><strong>Emergency care (no coverage if not a true emergency)</strong></td>
<td><strong>100% after $50 ER copay. $50 copayment, waived if admitted for any reason within 24 hours</strong></td>
<td><strong>100% after $50 copay. $50 copayment, waived if admitted for any reason within 24 hours</strong></td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Type of service</th>
<th>Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care facility</td>
<td>100% after $15 copayment</td>
<td>100% after $15 copayment</td>
</tr>
<tr>
<td>Outpatient lab and x-ray services</td>
<td>90% after deductible</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Outpatient short-term rehabilitation</td>
<td></td>
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<tr>
<td>Physical, speech, occupational or chiropractic therapy</td>
<td>90% after deductible, up to 60 visits per year for all types of therapy. This limit applies to network and out-of-network services combined.</td>
<td>80% of R&amp;C after deductible, up to 60 visits per year for all types of therapy. This limit applies to network and out-of-network services combined.</td>
</tr>
<tr>
<td>Durable medical equipment (includes orthotics/prosthetics and appliances)</td>
<td>90% after deductible</td>
<td>80% of R&amp;C after deductible</td>
</tr>
<tr>
<td>Home health care &amp; Private Duty Nursing</td>
<td>90% after deductible, limited to 200 visits annually for network and out-of-network services combined</td>
<td>80% of R&amp;C after deductible, limited to 200 visits annually for network and out-of-network services combined</td>
</tr>
<tr>
<td>Hospice (over age 65 includes Bereavement Counseling up to a $200 benefit per family unit)</td>
<td>90% after deductible</td>
<td>80% of R&amp;C after</td>
</tr>
<tr>
<td>Skilled nursing facility</td>
<td>90% after deductible (limited to 120 days annually for network and out-of-network services combined)</td>
<td>80% of R&amp;C after deductible (limited to 120 days for network and out-of-network services combined)  Pre-certification required</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>90% after deductible</td>
<td>80% of R&amp;C after deductable</td>
</tr>
<tr>
<td>Type of service</td>
<td>Network</td>
<td>Out-of-network</td>
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<tr>
<td></td>
<td>Covered when used for pain management or in lieu of anesthesia if provided by a physician or certified acupuncturist. Limited to 10 treatments per 30 day period, no coverage for treatment received for the same condition within a 6 month period.</td>
<td></td>
</tr>
</tbody>
</table>

**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 Open Choice PPO, referred to as the network level of benefits, you must receive care from preferred provider.

**Deductible**

If you elect to use physicians or other providers in the network, you will need to satisfy an annual deductible ($100 individual/$200 family) before any benefit will be paid. Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-network.

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

The family deductibles represent 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 deductibles. The family deductibles can be met as follows:

- **Two in a family**: Each member must meet the $100 individual deductible; or

- **Three or more in a family**: Expenses can be combined to meet the $200 family deductible, but no one person can apply more than the $100 individual deductible toward the family deductible amounts.
**Coinsurance**

Coinsurance refers to the specific percentage that you pay toward the cost of covered services and supplies. For example, the network coinsurance for some of the covered services in the chart above is 90%. This means that when you go to a network provider the plan pays 90% of the cost of the covered service and you pay the remaining 10%. For other covered services you pay a dollar amount up front to a network provider (copayment) and the plan pays 100% of the remaining cost of the covered service.

**Out-of-pocket maximum**

The individual out-of-pocket maximum for services rendered in the network is 2% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $2,500 (the family maximum is 2.5% of the benefit salary, rounded down to the next lower $25, not to exceed $3,125). This amount represents the most you will have to pay out of your own pocket in a calendar year for services received in the network. This amount does not include network copayments, penalties, or any expenses incurred for mental health/chemical dependency services, or services not covered under Open Choice PPO.

Once this out-of-pocket maximum is met, covered expenses are payable at 100% of the negotiated rate contracted with the Claims Administrator, for the remainder of the calendar year. However, network copayments still apply even after the out-of-pocket maximums are met.

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 to the family out-of-pocket maximum.

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

- Pharmacy expenses;
- Any charges for mental health/chemical dependency services;
- Charges for services not covered under the PPO plan;
- Any expense that would have been reimbursed if you had notified Open Choice PPO
- Copayments.


**Preventative Care**

Preventative care services are available in the Plan.

Each participant has a $250 annual credit toward all wellness services in and out of network combined. Covered expenses are covered at 100% up to $250 maximum then covered at 90%, no deductible.

- Routine physical exams: 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, contact your plan administrator.

- Routine diagnostic test. For example: CBC (complete blood count), cholesterol blood test, urinalysis;
- Well-child-care services and routine pediatric care; and
- Routine well-woman exams.

In addition, the PPO plan will cover both cancer-screening tests and well-child immunizations performed by network providers at 100% and are not subject to the $250 annual credit. Well Cancer screenings are:
  - Pap smear performed by a network provider annually;
  - 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;
  - Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

**Routine Care**

The PPO plan offers additional coverage for routine care services to help detect health problems early. The following are covered at 90%, after the deductible has been met.

- **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.
- **Hearing Aid:** One device per ear up to an adult maximum of $1,200 every 36 months, and a child maximum of $1,200 every 24 months.

**Primary care physician (PCP)**

It is important when seeking primary care services to choose a provider from the list of primary care physicians in the directory of network providers. A directory of the network providers who participate in the PPO plan is available directly from Aetna. You may call or visit Aetna’s Web site:

Aetna’s Web site — [www.aetna.com](http://www.aetna.com) or call 800-545-5862

Once you meet your deductible, the Plan will pay 90% of covered expenses that are received in-
Specialists
If you need the services of a specialist, you may seek care from a specialist directly, without a referral. Once you meet the deductible, the Plan will pay 90% of covered expenses that are received in-network.

Infertility
Open Choice PPO covers only the diagnosis and treatment of underlying causes of infertility.

For more specific information, contact Aetna directly.

Hospital
Hospital care (inpatient and outpatient) received through a preferred provider is covered at 90% for covered services. Services provided by a network physician in an out-of-network hospital are covered at the network benefit level. Please note that any charges submitted by an out-of-network hospital would be treated as out-of-network claims. Notification of an inpatient admission is required. Certain outpatient procedures and services require notification. 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 Citigroup retiree health care 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. See Precertification/notification. Non-emergency services provided in the emergency room are not covered by Aetna Open Choice PPO.

Urgent care
Urgent care centers consist of a network of physicians that may be used when immediate care is needed and a provider 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 Open Choice PPO’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 Open Choice PPO 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 Open Choice PPO plan or not approved by the Aetna Open Choice PPO Plan. In that case, the network provider may bill charges to you. However, these charges are not covered expenses under the PPO 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 Aetna medical plans** section.

**Out-of-network coverage**

You can use an out-of-network provider for medical services and still receive reimbursement under the Aetna Open Choice PPO Plan. These expenses generally are reimbursed at a lower level than network expenses, and you will have to meet a deductible. A list of Aetna’s preferred providers will be distributed without charge by contacting the Claims Administrator, in addition to being available on Aetna’s website.

For information about how to file a claim for out-of-network services or appeal a denied claim, see the **Claims and appeals for Aetna 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 (individual is 1% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $1,250/Family is 2% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $2,500) 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 individual deductible; or
- **Three or more in a family**: Expenses can be combined to meet the family deductible, but no one person can apply more than the individual deductible toward the family deductible amount.

The deductible is based on a percentage of the benefit salary in effect on the day preceding your retirement, or termination. Once you have met the deductible, Aetna Open Choice PPO normally pays 80% of reasonable and customary (R&C) charges for covered expenses that are received out-of-network.

Benefit salary is the pre-retirement annualized base salary rate which is frozen on July 1 of the year of retirement.

### Out-of-pocket maximum

The individual out-of-pocket maximum for services rendered outside of the network is 4% of the benefit salary in effect on the day preceding retirement, rounded down to the next lower $25, not to exceed $5,000 (the family maximum is 5% of the benefit salary, rounded down to the next lower $25, not to exceed $6,250). This amount includes the 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 Open Choice PPO. 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 to the family out-of-pocket maximum.

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 PPO plan;
- Any expense that would have been reimbursed if you had notified Aetna Open Choice PPO or precertified the care;
- Copayments.
In addition, expenses incurred when using network services count toward your out-of-network, out-of-pocket maximum.

Preventative Care

Preventative care services are available in the Plan.

Each participant has a $250 annual credit toward all wellness services in and out of network combined. Covered expenses are covered at 100% up to $250 maximum then covered at 80% of R&C, no deductible.

- Routine physical exams: 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, contact your plan administrator.

- Routine diagnostic test. For example: CBC (complete blood count), cholesterol blood test, urinalysis;

- Well-child-care services and routine pediatric care; and

- Routine well-woman exams.

In addition, the PPO plan will cover both cancer-screening tests and well-child immunizations performed by network providers. Well child immunizations are covered at 80% of R&C no deductible. Cancer screenings are covered at 100%, no deductible up to $250 maximum, then 80% of R&C.

Cancer screenings are:

- Pap smear performed by a network provider annually;

- 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;

- Prostatic-specific antigen (PSA) screening annually with a digital rectal exam in men age 50 and older.

Infertility

Aetna Open Choice PPO covers only the diagnosis and treatment of underlying causes of infertility.

For more specific information, contact Aetna directly.
Hospital

Hospital care (inpatient and outpatient) will be reimbursed at 80% 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 of an inpatient admission is required. Certain outpatient procedures and services require notification. See **Precertification/notification**.

Emergency room

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 Citigroup retiree health care 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, 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 Open Choice PPO 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.

<table>
<thead>
<tr>
<th>Action</th>
<th>Inpatient</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you call Aetna and use its network provider/facility</td>
<td>After deductible, eligible expenses covered at 90% of the negotiated rate;</td>
<td>After deductible, expenses covered at 90% of negotiated rate;</td>
</tr>
<tr>
<td>If you call Aetna but do not use its network provider/facility</td>
<td>After the deductible, eligible expenses covered at 80% of R&amp;C;</td>
<td>After the deductible, eligible expenses covered at 80% of R&amp;C;</td>
</tr>
<tr>
<td>If you do not call and do not use Aetna’s network provider/facility</td>
<td>After the deductible, eligible expenses covered at 80% of R&amp;C;</td>
<td>After the deductible, eligible expenses covered at 80% of R&amp;C;</td>
</tr>
</tbody>
</table>

*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 Open Choice PPO. Your copayments and coinsurance under the mental health and chemical dependency program may differ from those required for other covered services under Aetna Open Choice PPO.

Mental health benefits include, but are not limited to:

- Assessment, diagnosis, and treatment;
- Medication management;
- Individual, family, and group psychotherapy;
- Acute inpatient;
- Partial hospitalization programs;
- Facility based intensive outpatient program services;
- Psychological testing that is not primarily educational in nature.
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 Open Choice PPO to give notification of inpatient services. Aetna Open Choice PPO pays benefits at the network level (90% of negotiated rate contracted with the Claims Administrator) if you call the plan, use a network provider and the treatment is medically necessary and in the appropriate level-of-care setting. If you do not use a network provider, you will be reimbursed at 80% of R&C after the deductible is met provided that the treatment is medically necessary and in the appropriate level-of-care setting.

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.

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 be reimbursed 90% of covered expenses after the deductible is met. If you do not use the recommended provider, you will be reimbursed at 80% of R&C for covered services after the deductible is met.

**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.

**Medically necessary**

Aetna Open Choice PPO will help you and your physician determine the best course of treatment based on your diagnosis and acceptable medical practice. Aetna Open Choice PPO 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 Open Choice PPO 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 Open Choice PPO covers, see **Covered services and supplies**. You may also contact Aetna Open Choice PPO 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 Open Choice PPO covers.

**Retrospective Record Review**

If you are enrolled in the Aetna Open Choice PPO 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 Open Choice PPO 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.

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**Citigroup Prescription Drug Program**

Express Scripts manages the Citigroup Prescription Drug Program for participants in the Open Choice PPO Plan.

Express Scripts covers FDA (Food and Drug Administration)-approved (federal legend) medications that require a prescription from your doctor. The plan does not cover over-the-counter (OTC) products such as aspirin, vitamins, supplements, or other products that do not require a prescription.
Express Scripts offers two ways to purchase prescription drugs:
1. A network of retail pharmacies nationwide where you can obtain prescription drugs for your immediate short-term needs, such as an antibiotic to treat an infection.
2. Express Scripts Home Delivery through which you may save money by having your maintenance and preventive drugs delivered by mail.

You will pay a deductible, as shown in the chart below, for drugs purchased at a retail pharmacy before the Plan will pay benefits. You will never pay more than the cost of the drug.
### Prescription drug benefits at a glance

<table>
<thead>
<tr>
<th>Prescription Drug Benefits</th>
<th>ChoicePlan 500</th>
<th>High Deductible Health Plan*</th>
<th>Oxford PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual deductible (network and out-of-network combined)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>$100 per person (prescription drug deductible)</td>
<td>$1,800 network/$2,800 out of network; includes medical expenses</td>
<td>$100 per person (prescription drug deductible)</td>
</tr>
<tr>
<td><strong>Maximum per family</strong></td>
<td>$200 family maximum (prescription drug deductible)</td>
<td>$3,600 network/$5,600 out of network; includes medical expenses</td>
<td>$200 family maximum (prescription drug deductible)</td>
</tr>
</tbody>
</table>

Copayment for up to a 34-day supply at a network pharmacy after you meet your deductible

- **Generic drug****
- **Preferred brand name or formulary drug*****
- **Non-preferred brand name or non-formulary drug**
- You may have the same prescription filled up to three times at a retail pharmacy. On the fourth fill, you will pay 100% of the cost of the medication****

| | $5 | $30 | 50% of the cost of the drug with a minimum payment of $50 to a maximum of $150 |

Copayment for a 90-day supply through the Express Scripts Home Delivery program after you meet your deductible

- **Generic drug****
- **Preferred brand name or formulary drug*****
- **Non-preferred brand name or non-formulary drug**

| | $12.50 | $75 | 50% of the cost of the drug with a minimum payment of $125 to a maximum of $375 |
**PRESCRIPTION DRUG BENEFITS**

<table>
<thead>
<tr>
<th>ChoicePlan 500</th>
<th>High Deductible Health Plan*</th>
<th>Oxford PPO</th>
</tr>
</thead>
</table>

Copayment for a 30-day supply of specialty medication through the Accredo Specialty Pharmacy after you meet your deductible*****

- **Generic drug****
  - $5

- **Preferred brand name or formulary drug***
  - $75

- **Non-preferred brand name or non-formulary drug**
  - 50% of the cost of the drug with a minimum payment of $50 to a maximum of $150

Benefits at an out-of-network pharmacy

- 50% of your cost after you meet the deductible; you must file a claim for reimbursement

* In the High Deductible Health Plan, you must meet your combined medical/prescription drug deductible before the Plan will pay benefits except for certain preventive drugs. For a list of these preventive drugs, call Express Scripts at 1-800-227-8338 or visit www.express-scripts.com. Your cost for these preventive drugs is the applicable copayment or coinsurance, which will count toward your out-of-pocket maximum.

** The use of generic equivalents whenever possible (through both the retail and Express Scripts Home Delivery programs) is more cost-effective. Ask your medical professional about this distinction. 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 in addition to the copayment for the generic drug.

*** Citi does not determine formulary drugs. Rather, Express Scripts brings together an independent group of practicing doctors and pharmacists who meet quarterly to review the formulary list and make determinations based on current clinical information. Call Express Scripts at 1-800-227-8338 for a copy of its Preferred Formulary or visit www.express-scripts.com.

**** Retail pharmacy purchases are not reimbursable under the Plan after three refills of the same drug.

***** Except in case of an emergency, each prescription for specialty medications can be filled only twice through a retail pharmacy. For third and future refills, you are required to fill the prescription through Accredo.

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**Retail network pharmacies with Express Scripts**

When you need a prescription filled the same day, for example, an antibiotic to treat an infection, you can go to one of the thousands of pharmacies nationwide that participate in the Express Scripts network and obtain up to a 34-day supply for your copayment (once you meet your deductible).

For some drugs to be covered, you may have to provide a letter from your physician. Prescriptions may be screened for specific requirements and must be related to the diagnosis for which they are prescribed.

If you expect to have the prescription filled more than three times, use the Express Scripts Home Delivery program.

To find out whether a pharmacy participates in the Express Scripts network:

- Ask your pharmacist;
- Visit www.express-scripts.com and use the online pharmacy locator; or
- Call Express Scripts at 1-800-227-8338 and follow the prompts for the retail pharmacy locator.
A network pharmacy will accept your prescription and prescription drug ID card, and, once you have met your deductible, charge the appropriate copayment/coinsurance for a covered drug. Your copayment/coinsurance will be based on whether your prescription is for a generic drug, a preferred brand-name drug on the Express Scripts Preferred Formulary, or a non-preferred brand-name drug.

Send all completed claim forms to:

Express Scripts Pharmacy
P.O. Box 66583
St. Louis, MO 63166

**Using your prescription drug ID card**

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

You will have a 45-day grace period from the effective date of your enrollment in which you will be covered even though you do not present your prescription drug ID card when purchasing drugs at a retail pharmacy. If you do not present your prescription drug ID card at the time of service during this initial 45-day period, you will still be reimbursed for 100% of the cost of any covered drugs, less the network copayment, after meeting the annual deductible.

If you do not use your card at network pharmacies after your first 45 days of participation, you will be reimbursed for only 50% of the cost of the prescription drug after you have met the annual deductible.

In either case, you must pay the entire cost of the prescription drug and then submit a claim form to be reimbursed.

**Meeting your deductible**

When you buy a prescription drug, you must meet the applicable deductible (individual or family) before the Plan will pay benefits.

For answers to your questions about the applicable deductibles, call Express Scripts at 1-800-227-8338.

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**Express Scripts Home Delivery**

For prescriptions for maintenance medications that you have filled more than three times, you must use the Express Scripts Home Delivery program to avoid paying 100% of the cost of the drug.

Through Express Scripts Home Delivery you can buy up to a 90-day supply at one time. You will make one copayment for each prescription drug or refill after you first meet your deductible, and your cost will be less than what you would pay to purchase the same amount at a retail network pharmacy.

When you use Express Scripts Home Delivery:

- Your medications are dispensed by one of Express Scripts Home Delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no cost to you. You will pay for express shipping.
- You can order and track your refills online at www.express-scripts.com, or you can call Express Scripts at 1-800-227-8338 to order your refill by telephone.
- Registered pharmacists are available 24/7 for consultations.
**Obtaining a refill of a maintenance medication with Express Scripts**

The first three times you purchase a maintenance medication at a retail network pharmacy or out-of-network pharmacy after you meet the applicable deductible, you will pay the applicable copayment or coinsurance. You will receive a notice from Express Scripts advising you of the benefits of the Express Scripts Home Delivery program.

If, after the prescription is filled three times, you still want to purchase this maintenance medication at a retail pharmacy instead of through Express Scripts Home Delivery, you will pay 100% of the cost of the current prescription or a new prescription for the same medication and strength. Maintenance drugs, generally, are drugs taken on a regular basis for conditions such as asthma, heartburn, blood pressure, and high cholesterol. If you need to know if your prescription drug is considered a maintenance medication, call Express Scripts at 1-800-227-8338.

**Specialty medication with Express Scripts**

Accredo — Express Scripts’ specialty pharmacy — dispenses oral and injectable specialty medications for the treatment of complex chronic diseases, such as, but not limited to, multiple sclerosis, hemophilia, cancer, and rheumatoid arthritis. Prescriptions sent to Express Scripts Home Delivery that should be filled by Accredo will be forwarded. Specialty medications purchased through Accredo are limited to a 30-day supply.

Accredo offers the following:

- Once you are using the Accredo program, Accredo will call your doctor to obtain a prescription and then call you to schedule delivery.
- Prescription drugs can be delivered via overnight delivery to your home, work, or doctor’s office within 48 hours of ordering.
- You are not charged for needles, syringes, bandages, sharps containers, or any supplies needed for your injection program.
- A Accredo team of representatives is available to take your calls, and you can consult 24/7 with a pharmacist or nurse experienced in injectable medications.
- Accredo will send monthly refill reminders to you.

To learn more about Accredo’s services, including the cost of your prescription drugs, call Accredo at 1-866-413-4135.

**Exclusive Accredo**

Citi participates in the “Exclusive Accredo” program, which means that, except in the case of an emergency, you can fill a prescription for a specialty medication only twice through a retail pharmacy. After that, the pharmacy will reject the prescription and you will be required to fill it through Accredo.

In the event of an emergency, you are permitted to fill the prescription more than twice at a retail pharmacy. You will continue to be charged only the applicable retail/specialty copay.

**Controlled substances with Express Scripts**

Upon request, Express Scripts will fill prescriptions for controlled substances for up to a 90-day supply, subject to state limits.
Because special requirements for shipping controlled substances may apply, Express Scripts uses only certain Home Delivery pharmacies to dispense these medications. If you submit a prescription for a controlled substance along with other prescriptions, it may need to be filled through a different pharmacy from your other prescriptions. As a result, you may receive your order in more than one package.

For more information about controlled substances and for the laws in your state, call Express Scripts at 1-800-227-8338.

**Note:** Kentucky and Hawaii state laws require you to provide your Social Security number or government ID to the pharmacy or to Express Scripts before it can dispense your medication(s).

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**Generics Preferred with Express Scripts**

The Generics Preferred program was designed to encourage the use of generic drugs instead of brand-name drugs. Typically, brand-name medications are 50% to 75% more expensive than generics.

If you choose the brand-name drug, where a generic exists, you must pay the difference between the brand and generic in addition to your copayment. *Express Scripts will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.*

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**Prior authorization with Express Scripts**

To purchase certain medications or to receive more than an allowable quantity of some medications, your pharmacist must receive “prior authorization” from Express Scripts before these drugs will be covered under the Citigroup Prescription Drug Program.

- Examples of medications requiring “prior authorization” are Retin-A cream, growth hormones, anti-obesity medications, rheumatoid arthritis medications, and Botox.

- Examples of medications whose quantity will be limited are smoking cessation products, migraine medications, and erectile dysfunction medications.

Other medications, such as certain non-steroidal anti-inflammatories, will be covered only in situations where a lower-cost alternative medication is not appropriate.

To determine if your medication requires a prior authorization or is subject to a quantity limit, call Express Scripts at 1-800-227-8338 or visit the Express Scripts website at www.express-scripts.com. Your pharmacist can also determine if a prior authorization is required or a quantity limit will be exceeded at the time your prescription is dispensed.

If a review is required, you or your pharmacist can ask your doctor to initiate a review by calling 1-800-224-5498. After your doctor provides the required information, Express Scripts will review your case, which typically takes one to two business days. Once the review is completed, Express Scripts will notify you and your doctor of its decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you can purchase the drug at full cost.
Medical necessity review (for non-formulary drugs) with Express Scripts

Under certain circumstances, you and your doctor may request that Express Scripts perform a medical review of your medications. For additional information and instructions on how your doctor can request a review, call Express Scripts at 1-800-227-8338.

For Medicare eligible retirees in Express-Scripts prescription drug coverage.

Effective April 1, 2013 Citigroup Inc. (Citi) prescription drug coverage changed from the Citigroup Prescription Drug Program to Express Scripts Medicare™ (PDP)1.

Express Scripts Medicare™ (PDP) is considered Creditable Coverage, which means it is at least as good as the standard Medicare Part D prescription drug coverage. A Medicare Part D prescription drug plan offers the best opportunity for cost control for both retirees and Citi while also providing comprehensive prescription drug benefits.

Eligibility

You are eligible for this plan if you are:

- entitled to Medicare Part A and Medicare Part B;
- age 65 or older, disabled or have end-stage renal disease;
- a Citi retiree (or the Medicare – eligible spouse of a retiree); and
- currently enrolled in a Citi Retiree Medical Benefit Plan, not including any Medicare Advantage Plans, including those offered by Citi; and.
- A member of the retiree group eligible based on employment history

If you are currently enrolled in a Medicare Advantage (MA) Plan with or without Medicare prescription drug coverage, your enrollment in Express Scripts Medicare may end that enrollment. In addition, you may not be enrolled in an individual MA Plan—even one without prescription drug coverage—at the same time that you are covered by the Express Scripts Medicare™ (PDP)

Enrollment

If you are eligible, you will automatically be enrolled in the Express Scripts Medicare™ (PDP) unless you decline coverage by calling the Citi Benefits Center informing them you don’t want to be enrolled

within 21 days of receipt of the letter you will receive from Express Scripts advising you of your eligibility for the Express Scripts Medicare™ (PDP)

Enrollment in the Express Scripts Medicare™ (PDP) may cancel your enrollment in the following types of plans:

1 PDP stands for Prescription Drug Plan
• Another Medicare Part D plan;
• A Medicare Advantage Plan with prescription drug coverage (MA-PD); and
• A Medicare Advantage Plan not sponsored by Citi.

If you are currently in a Medicare prescription drug plan, a Medicare Advantage Plan with prescription drug coverage, or an individual Medicare Advantage Plan through private insurance or a spouse’s plan, and then you are subsequently enrolled in the Express Scripts Medicare™ (PDP) your enrollment in Express Scripts Medicare™ (PDP) can end your enrollment in your private insurance plans or your spouse’s plan. If you are enrolled in the Express Scripts Medicare™ (PDP) and then enroll in any of the Medicare Part D coverages listed above, your enrollment in the Express Scripts Medicare™ (PDP) may be terminated by CMS.

If you have been enrolled in the Express Scripts Medicare™ (PDP) and later enroll into a Citi sponsored Medicare Advantage plan your enrollment in the Express Scripts Medicare™ (PDP) will be terminated.

**Important: If you choose a prescription drug plan other than Express Scripts Medicare™ (PDP) through Citi, this decision may impact your benefits. For example you may be able to continue in your medical plan but may terminate our Citi prescription coverage and you may not be able to enroll back into Citi prescription drug coverage at a later date. Please contact the Citi Benefits Center through ConnectOne at 1-800-881-3938 for more information before making a decision to leave this plan, or for information about other options that may be available to you.**

From the ConnectOne main menu, choose the “pension and retiree health and welfare” option to speak with a Citi Benefits Center representative. Representatives are available from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

If you wish to remain enrolled in Express Scripts Medicare™ (PDP), there is no action you need to take. Starting the first day of the month you are eligible, be sure to present your new Express Scripts Medicare™ (PDP) ID card when filling a prescription at an Express Scripts Medicare network pharmacy.

Express Scripts Medicare™ (PDP) is a Medicare Part D prescription drug plan, which is in addition to your coverage under Medicare Part A and Part B. Your enrollment in this plan doesn’t affect your coverage under Medicare Part A and Part B. It is your responsibility to inform Express Scripts Medicare™ (PDP) of any prescription drug coverage that you have or may get in the future. You can be in only one Medicare prescription drug plan at a time.

If you need assistance deciding whether to remain in the Express Scripts Medicare™ (PDP) or to enroll in another prescription drug plan (for example a plan purchased through private insurance) you can contact Health Advocate at 1-866-449-9933.
Enrollment in **Express Scripts Medicare™** (PDP) is not mandatory. However it is the only prescription drug plan coverage available to you through Citi unless you enroll in a Citi sponsored Medicare Advantage Plan. Citi sponsored Medicare Advantage Plans include their own prescription drug coverage. If you choose not to enroll in the **Express Scripts Medicare™** (PDP), you should retain other Medicare Part D coverage you may have or enroll in other prescription drug coverage as soon as possible or you may be subject to a late enrollment penalty (LEP) assessed by the Center for Medicare and Medicare Services (“CMS”) if you do enroll in Medicare Part D prescription drug coverage if you go 63 days or more without Medicare Part D coverage or other credible prescription drug coverage (see information on creditable coverage and when you should enroll). **If you decline the Express Scripts Medicare™** (PDP) coverage, **Citi will not permit you to reenroll in this prescription drug coverage at a later date.** In most cases your medical/prescription drug premium will not be reduced even if you drop Citi prescription drug coverage provided through **Express Scripts Medicare™** (PDP).

In general, if you opt out of **Express Scripts Medicare™** (PDP), which is the only Citi sponsored prescription drug plan coverage, you can join another Medicare Part D prescription drug plan during the Medicare Part D prescription drug plan annual enrollment period from October 15 to December 7. Except in special cases, you cannot join a new plan at any other time of the year unless you qualify for a 60 day Special Enrollment Period (SEP) after you lost creditable coverage. Rules about when you can make changes and the type of changes you can make are different for each type of SEP. You can, however, join or leave a plan at any time if Medicare decides that you need Extra Help with paying the plan costs. If Medicare decides that you no longer need Extra Help, you will have two months to make changes after Medicare notifies you of its decision. For more information on a SEP or the Extra Help program, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week for assistance. TDD users should call 1-877-486-2048.

**Coverage for Dependents Under Age 65**

If you have a dependent who is under age 65 and has coverage through the Citigroup Prescription Drug Program, he or she will be able to retain his/her current plan coverage as long as he/she continues to meet the eligibility requirements as detailed in the official Plan Documents available on Your Benefits Resources™ (YBR™). You can also request to receive a copy of the plan document by calling the Citi Benefits Center. For detailed information about coverage for your dependents under age 65, see the section in this document titled “Citigroup Prescription Drug Program”.

**Grievances and Appeals**

Once you are a member of **Express Scripts Medicare™** (PDP), you have the right to file a grievance or appeal plan decisions about payment or services if you disagree. An explanation on filing a grievance or appeal can be found in the Evidence of
Coverage notice which is provided to plan participants after enrollment in the plan. You can also contact Express Scripts and request information on how to file a grievance or appeal.

**Release of Information to Medicare**

By joining this Medicare Part D prescription drug plan, you acknowledge that Express Scripts Medicare™ (PDP) can release your information to Medicare and other plans as is necessary for treatment, payment, and health care operations. You also acknowledge that Express Scripts Medicare™ (PDP) can release your information, including your prescription drug event data, to Medicare, who may release it for research and other purposes that follow all applicable Federal statutes and regulations.

**Centers for Medicare & Medicaid Services (“CMS”) Plan Approval**

CMS must approve the Express Scripts’ plan each year. You can continue to get Medicare coverage as a member of this plan only as long as both Express Scripts and Citigroup Inc. choose to continue to offer this plan, and CMS renews its approval of Express Scripts’ plan.
## Benefit Overview

**Express Scripts Medicare**™ (PDP) for Citigroup Inc.

### YOUR 2014 PRESCRIPTION DRUG PLAN BENEFIT

The benefit described in this document is your benefit after combining the standard Medicare Part D benefit with additional coverage being provided by Citigroup Inc. (Citi). The following table provides a summary of your benefit, including deductible and cost-sharing information. This plan provides coverage across all stages of your benefit.

<table>
<thead>
<tr>
<th>Deductible stage</th>
<th>You pay an annual $100 deductible per person enrolled in Express Scripts Medicare.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Coverage stage</strong></td>
<td>After you pay your annual deductible, you will pay the following until your total annual drug costs (what you and the plan pay) reach $2,850:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail One-Month (34-day) Supply</th>
<th>Retail Three-Month (90-day) Supply</th>
<th>Home Delivery Three-Month (90-day) Supply</th>
<th>Specialty (34-day) Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic Drugs</td>
<td>$5 copayment</td>
<td>$15 copayment</td>
<td>$12.50 copayment</td>
<td>$5 copayment</td>
</tr>
<tr>
<td>Tier 2: Preferred Brand Drugs</td>
<td>$30 copayment</td>
<td>$90 copayment</td>
<td>$75 copayment</td>
<td>$75 copayment</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred Brand Drugs</td>
<td>47.5% with $150 max</td>
<td>47.5% with $450 max</td>
<td>47.5% with $375 max</td>
<td>47.5% with $150 max</td>
</tr>
</tbody>
</table>

If your doctor prescribes less than a full month’s supply of certain drugs, you will pay a daily cost-sharing rate based on the actual number of days of the drug that you receive.
<table>
<thead>
<tr>
<th>Coverage Gap stage</th>
<th>After your total annual drug costs reach $2,850, you will pay the same cost-sharing amount as in the &quot;Initial Coverage stage&quot; (outlined above) until your annual out-of-pocket drug costs reach $4,550.</th>
</tr>
</thead>
</table>
| Catastrophic Coverage stage | After your annual out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts received by Express Scripts but excluding payments made by your Medicare prescription drug plan) reach $4,550, you will pay the greater of 5% coinsurance or:  
- A $2.55 copayment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage.  
- A $6.35 copayment for all other covered drugs, with a maximum not to exceed the standard cost-sharing amount during the Initial Coverage stage. |
| In-network retail pharmacy | All network retail pharmacies in your plan can provide you with a 34-day supply up to a 90-day supply of your prescription. Certain retail pharmacies may be able to provide you with a 90-day supply of your prescription. Please contact Customer Service at the numbers on the back of this document to find out if your pharmacy offers up to a 90-day supply. For a 90-day supply you will pay three times the standard 34-day supply retail copayment. |
| General information/restrictions | • In some cases, you may need to first try one drug to treat your medical condition before your plan will cover another drug for that condition.  
• Certain prescription drugs will have maximum quantity limits.  
• Your provider must get prior authorization from Express Scripts for certain prescription drugs.  
• There is no penalty for brand drugs where a generic is available, though these brand drugs will generally cost more.  
• You may receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) by mail through our home delivery service. There is no charge for standard shipping.  
• Not all drugs are available at a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please contact Express Scripts Medicare Customer Service at the numbers on the last page of this document for more information. |
| Right to appeal | If you are ever denied coverage for your prescription drugs, Express Scripts will explain their decision to you. You have the right to appeal and ask them to review denied claims. |
| Out-of-network pharmacies | Covered drugs are available at out-of-network pharmacies in special circumstances, including illness while traveling outside of the plan’s service area where there is no network pharmacy. You may incur an additional cost for drugs purchased at an out-of-network pharmacy. Please contact Customer Service at the numbers on the last page of this document for more details. |

**Long-Term Care (LTC) Pharmacy**

Long-term care pharmacies must dispense brand-name drugs in amounts less than a 14-day supply at a time. They may also dispense less than a one month’s supply of generic drugs at a time. Contact your plan if you have questions about cost-sharing or billing when less than a one-month supply is dispensed.
Certain dollar limits and thresholds may change each year in January including dollar limits before and after the coverage gap stage; and catastrophic stage copays. You will be notified of these CMS determined changes each year during annual enrollment.

ID Cards
You will receive a Welcome Kit from Express Scripts for your new plan prior to the first day of the month you are eligible. Your Welcome Kit will include your new Medicare prescription drug plan member ID card. You should use this card beginning on the first day of the month you are eligible. Do not discard your medical coverage ID card; you should continue to use your medical card for any medical related services. Your Welcome Kit will also include other important plan benefit materials, such as a formulary (a list of drugs covered by your plan).

Prior Authorization
If you are currently taking a drug that requires prior authorization, follow the instructions below.

Current Express Scripts members:
You may currently have a prescription for which you have obtained a prior authorization or prior approval from your current plan administered by Express Scripts. If your medication also requires a prior authorization under your new plan, you may need to obtain a new approval. Existing authorizations from your current plan may not be carried over into your new plan.

Members who are new to Express Scripts:
As is common with many prescription drug plans, certain drugs will require a prior authorization or approval prior to the plan providing coverage. The Medicare formulary that is sent with the Welcome packet identifies all the drugs for which a prior authorization could apply by noting a (P) next to the drug name. Review the formulary document that you will receive in your Welcome Kit packet prior to your effective date to determine which drugs will require a prior authorization.

If your drug requires a prior authorization, call Express Scripts Customer Service at 1-877-328-9303 after your membership becomes effective. Express Scripts will then start the prior authorization process with your provider. Please note, due to differences in plan rules, it is possible that your prior authorization may not be approved. In that case, you may need to work with your provider to find an alternative drug.

If you run out of your medication before your prior authorization is processed, you may be given up to a 34-day temporary supply of a Medicare Part D medication at your pharmacy.

Obtaining Prior Authorization
Your pharmacist will inform you if your medication requires prior authorization. You can also call Express Scripts at 1-877-328-9303 to ask whether your medications require prior authorization.

You or your pharmacist can ask your doctor to initiate a coverage review by calling 1-877-328-9303.

After your doctor provides the required information, Express Scripts will review your case, which typically takes one to two business days. Once the review is completed, Express Scripts will notify you and your doctor of its decision. If your medication or the requested quantity is not approved for coverage under Express Scripts Medicare™ (PDP), you can purchase the drug at full cost.

Remaining Refills

If you are a current Express Scripts member and use its mail order pharmacy, your open refills will be transferred to the Express Scripts Medicare pharmacy. If you currently use a retail pharmacy, regardless of whether or not you are a current Express Scripts member effective the first day of the month you are eligible, you must use Express Scripts Medicare network pharmacies to fill your prescriptions. You must also use your new ID card on or after the first day of the month you are eligible.

Filling a prescription

Your prescriptions can be filled at an Express Scripts Medicare network pharmacy by presenting your Express Scripts Medicare™ (PDP) ID card. You must use the Express Scripts Medicare network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan’s service area where there is no network pharmacy. You may incur additional costs for drugs received at an out-of-network pharmacy. For more information call Express Scripts at 1-877-328-9303.

Service area of Express Scripts Medicare™ (PDP)
The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to join this plan.

Information about the prescription drug coverage offered by Express Scripts Medicare™ (PDP) and how much you will pay for a “generic”, “preferred”, “non-preferred” or specialty drug?
See the 2014 Benefits Overview included in this section. You also have the following resources available to you to obtain prescription drug coverage information about the cost of a medication under your prescription drug coverage through Express Scripts Medicare™ (PDP):

- Go to the Your Benefits Resources™ (YBR™) to review summary descriptions of the benefit plans, including how they work and what’s covered;

- Call Express Scripts.
Plan Formulary

The plan uses a formulary—a list of covered drugs. Express Scripts Medicare™ (PDP) may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified before the change becomes effective.

Formulary Exceptions
If you request a formulary exception for a drug and Express Scripts Medicare™ (PDP) approves the exception, you will pay the Preferred Brand Drug cost-share for that drug.

Step Therapy
The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. This is sometimes referred to as step-therapy.

Actual Cost of a Drug
If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

Monthly Premium
If applicable, you will need to pay a monthly premium amount each month to continue your participation in Express Scripts Medicare™ (PDP). For more information about the monthly premium you pay each month for medical (including prescription drug) coverage:

- Visit YBR™ at http://resources.hewitt.com/citigroup; or
- Call the Citi Benefits Center via ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the “pension and retiree health and welfare” option to speak with a Citi Benefits Center representative.

In addition, you must continue to pay your Medicare Part B premium (if not otherwise paid for under Medicaid or by another third party). You must be enrolled in Medicare Part A and B to be enrolled in a Medicare Part D Plan.

Qualifying for Extra Help to pay for prescription drug premiums
To see if you qualify for Extra Help, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TDD users should call 1-877-486-2048; the Social Security Office at 1.800.772.1213 between 7 a.m. and 7 p.m., Monday through Friday (TDD users should call 1-800-325-0778); or your State Medicaid Office. If you qualify, Medicare will tell the plan how much assistance you will receive, and Express Scripts Medicare™ (PDP) will send you information on the amount you will pay once you are enrolled in this plan.

Income and Medicare Part D premiums
Some people may have to pay an extra amount for Express Scripts Medicare™ (PDP) coverage because of their yearly income. If you have to pay an extra amount, the Social Security Administration (SSA)—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. The extra amount will be withheld from your SSA or Office of Personnel Management benefit check. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium. If you have any questions about this extra amount, contact SSA at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TDD users should call 1-800-325-0778.

Important Information Regarding Medicare Part D premium surcharge

Individuals with higher incomes are required to pay an additional amount for their Part D coverage. This additional amount is called the Medicare Part D Income Related Monthly Adjustment Amount (“Part D-IRMAA”), and it is mandated by Affordable Care Act. Part D-IRMAA is an extra amount an individual has to pay the federal government each month in addition to their Part D plan premium in order to maintain Part D coverage. Part D-IRMAA is only assessed to individuals with an annual income reported (as reported in most recent income tax filing) to be over $85,000 for an individual/separate filing married couple or over $170,000 for joint filing married couples.

Paying Part D-IRMAA

Anyone with Part D coverage, regardless of how they have the coverage, has to pay the Part D-IRMAA if their income meets the required threshold. This includes participants in self insured employer Part D Plans, such as Express Scripts Medicare™ (PDP) and Medicare Advantage Plans that include prescription drug benefits. It also includes plans offered through the individual Medicare plan market. Individuals in employer plans are not exempt from paying Part D-IRMAA. Part D-IRMAA has to be paid for each month the individual has Part D coverage during the year that the IRMAA was assessed.

Employers cannot pay the Part D-IRMAA for their members as a third party payer. Individuals who have their Part B or premium Part A premiums paid for by employers/unions still have to pay the Part D-IRMAA themselves.

Social Security determines who has to pay the Part D-IRMAA and they notify individuals in their annual Benefits Rate Increase letter (in November), or when the individual initially enrolls in Part D coverage. Social Security sends the letters to the address within their files. This may not be a current address for individuals as some are not collecting a Social Security benefit and the address information may be outdated. Medicare uses the address information from Social Security to send the Part D-IRMAA bills to individuals.

Contesting the Part D-IRMAA assessment
If a member is billed for Part D-IRMAA and disagrees (for example, they have a life event that lowers their income), they can call SSA at 1-800-772-1213. TTY users should call 1-800-325-0778. For more information, visit www.socialsecurity.gov.

**Late Enrollment Penalty as a Member of this Plan**
Express Scripts will send you notification if Medicare (the Centers for Medicare & Medicaid Services, or CMS) has identified you as having to pay a late enrollment penalty (LEP). If you are subject to a LEP and your coverage is terminated by you or Citi, you will be responsible for paying the LEP if you enroll in another plan at a later date. If you remain enrolled in the Citi plan you will be charged the LEP through your monthly Citi premium.

**Coverage for Medicare Part B or Part D drugs**
As an enhancement to this plan, Citi will continue to cover Part B medications under Express Scripts Medicare™ (PDP).

**Medication Therapy Management (MTM) Program**
A Medication Therapy Management (MTM) Program is a free service offered to help you manage your medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You are not required to participate, but it is recommended that you do so in order to take full advantage of this covered service if you are selected.

**Locating Express Scripts Medicare network pharmacies**
This can be done in a couple of different ways:
- Visit the Express Scripts website at [www.express-scripts.com](http://www.express-scripts.com) and use the online Medicare network pharmacy locator; or
- Call Express Scripts. **Member Number: 877.328.9303**

**For more information**
For more detailed information about your Medicare prescription drug coverage and this plan’s specific costs, please review your other plan materials.

To find out what’s covered under **Express Scripts Medicare**™ (PDP), locate a network pharmacy in your area, fill prescriptions for maintenance medications, setup home delivery, obtain a prior authorization, and more, contact Express Scripts:
- **By web:** [www.express-scripts.com](http://www.express-scripts.com)
- **By phone:** 1-877-328-9303

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TDD users should call 1-877-486-2048. Or via the Internet at [http://www.medicare.gov](http://www.medicare.gov).
Citi Prescription Drug Coverage and Medicare

Medicare Prescription Drug Coverage Part D

Medicare offers prescription drug coverage for everyone with Medicare. This coverage is called “Part D.” Medicare prescription drug coverage can protect against future drug costs and give you access to drugs that you can use to stay physically and mentally healthy. To get Medicare drug coverage, you must join a Medicare drug plan. Medicare drug plans are run by insurance companies and other private companies approved by Medicare.

Before you decide to join a Medicare prescription drug plan, be sure you understand the implications of doing so:

- You have prescription drug coverage under your current Citigroup medical plan. If you enroll in Medicare Part D, you may become ineligible for prescription coverage under the Citigroup plan.
- If you drop your Citigroup prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citigroup coverage back at a later date if you so choose. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

Covered services and supplies

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 Plans.

You and your physician decide which services and supplies are required, but the Plans only pays 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 Plans 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.

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 except when done for dental care not covered by the plan.

Anesthesia is not covered when rendered in the doctor’s office or when administered by the operating surgeon.

**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**

Diagnostic screenings not subject to precertification or notification include:

- Mammogram;
- Pap smear;
- Prostatic-specific antigen (PSA);
- Sigmoidoscopy; and
- Colonoscopy.

**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;
- 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 Choiceplans:** 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

**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 Claims Administrator 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 Open Choice PPO plan** 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 are covered regardless of reason for hearing loss. Hearing aid coverage for:

- **Adults**: benefit up to $1,200 once every 36 months
- **Children**: benefit is up to $1,200 once every 24 months.

**Home health care (combined with Private duty nursing)**

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);
- 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 200 visits each calendar year (combined visits with private duty nursing). Each period of home health care aide 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.

**Hospice care**

Hospice services are provided for a participant who is terminally ill, and include the following:

- Room and board coverage is limited to expenses for the regular daily charged 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 Open Choice PPO plan 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;
  - 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 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**

Diagnosis of infertility and surgical correction of a medical condition causing infertility are covered subject to the Plan’s copayment or deductible and coinsurance.

Covered services include:

- Services for diagnosis and treatment of the underlying medical condition:
  - Initial evaluation, including history, physical exam, and laboratory studies;
  - Physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of the recipient and to stimulate the ovarian function of the donor;
  - 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
  - Harvesting of plan participant eggs;
  - 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);
  - *Note to Citi – this is in the Exclusions (?)* Medical expenses for infertility treatment are covered up to a lifetime maximum of $24,000.
  - Prescription drug expenses associated with infertility treatment are covered up to a lifetime maximum of $7,500, through the Prescription drug program.

The Aetna Open Choice PPO covers only the diagnosis and treatment of underlying causes of infertility and does not cover medical infertility treatment.

*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. (covers medical transportation services outside of these geographic areas to and from the nearest medical facility.)

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. Ambulettes are not covered.

**Morbid Obesity Expenses (non-HMO plans)**

Covered Medical Expenses include charges made on an inpatient or outpatient basis by a hospital or a physician for the surgical treatment of morbid obesity of a covered person. Limitations apply. For more information, contact your Health Plan directly.

Dietician/Nutritionist coverage is also available for Morbid Obesity. Please see the Dietician/Nutritionist section.

**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 Plan pays first (the primary plan) for oral surgery if needed as a necessary, but incidental, part of a larger service in treatment of an underlying medical condition.

The following oral surgeries are considered medical in nature and covered under the medical plan as necessary:

- Treat a fracture, dislocation, or wound.
- Cut out:
  - teeth partly or completely impacted in the bone of the jaw;
  - teeth that will not erupt through the gum;
  - other teeth that cannot be removed without cutting into bone;
  - the roots of a tooth without removing the entire tooth;
  - cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection
with the removal, replacement or repair of teeth.

- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement

Corrective surgery is covered if medically necessary for purposes of chewing and speaking.

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 the Plan:

- Oral surgery;
- Full or partial dentures;
- Fixed bridgework;
- Prompt repair to sound and natural teeth; and
- Crowns.

**Organ/tissue transplants**

Your Claims Administrator must be notified at least 17 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 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 Open 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.

Members must receive precertification for transplant procedures. When a member or physician calls Aetna to precertify a transplant evaluation, a case nurse will direct them to an Institutes of Excellence facility.

For UnitedHealthcare, United Resource Networks (URN) will coordinate your transplant activity. When an URN facility is used, benefits will be paid at 100% with access to the travel and lodging benefit. 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 plan.)

**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

- If the patient is a covered dependent minor child, the transportation expenses of two companions (one companion for Aetna plans). 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.

*NNOTE to Citi: this information is already covered earlier in the benefit.* For more information, contact your Claim Administrator directly. *NOTE TO CITI: members contact the Claim Administrator, not the Citi Health Plan.

**Orthoptic training**
Training by a licensed optometrist or an orthoptic technician. The Plan covers 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.

**Outpatient occupational therapy**

See rehabilitation therapy.

**Outpatient physical therapy**

See rehabilitation therapy.

**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 Claims Administrator.

- **Aetna Open Choice PPO plan**: there is a combined network and out-of-network maximum benefit of 200 visits per calendar year combined with Home Health Care. One visit is equal to one eight-hour shift. Inpatient private-duty nursing is not covered.

**Psychologist services**

Services of a psychologist for psychological testing and psychotherapy.

**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

- 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);
  - Accidental injury that happens while the person is covered under the Health Plan;
Chronic conditions (such as cerebral palsy or multiple sclerosis); or
- Developmental delay.

**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.

**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;

**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.

**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**
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% 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.

Multiple surgical procedures

If you’re using an out-of-network provider for a surgical procedure, the following multiple surgical procedure guidelines will apply. If more than one procedure will be performed during one operation — through the same incision or operative field — the Plan will pay according to the following guidelines:

- Primary procedure: The Plan will allow 100% of the negotiated or reasonable and customary fee.
- Secondary procedure: The Plan will allow 50% of the negotiated or reasonable and customary fee.
- Tertiary and additional procedures: The Plan will allow 50% of the negotiated or reasonable and customary for each additional procedure.
- Bilateral and separate operative areas: The Plan will allow 100% of the negotiated or reasonable and customary fee for the primary procedure and 50% of the secondary procedure and 50% of the negotiated or reasonable and customary fee for tertiary/additional procedures. If billed separately, incidental surgeries won’t be covered.
An incidental surgery is a procedure performed at the same time as a primary procedure and requires little additional physician resources and/or is clinically an integral part of the performance of the primary procedure.

Covered expenses for multiple surgical procedures are subject to the Claim Administrator’s 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.

**Wellness benefit**
Covered expenses include:
- Routine physical examination (including well-woman exams);
- Immunizations;
- Vision examination;
- Weight control (not covered by Aetna); and
- Stress management (not covered by Aetna).

There is a $250 calendar year maximum that applies per covered family member. This maximum does not apply to wellness visits to Choiceplan network providers, or for well-child care and immunizations.

**Women’s Health and Cancer Rights Act of 1998**
Your group health plan benefits described in this document 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 the retire health plans.

- 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 Plan;
- Any services or supplies that are not medically necessary, as determined by the Claim Administrator;
- 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 Claim Administrator;
- 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 Plan, 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 Plan covers 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.

- 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. Treatment
to improve the ability to chew or speak may be covered if medically necessary. 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 Plan does
  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, and learning disabilities are not covered by the Plan; See Covered services and
  supplies for limited coverage of cognitive services;

- 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 a claim;

- Expenses incurred by a dependent if the dependent is covered as an employee for the same
  services under the 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 Claim Administrator, unless approved by the Claim Administrator in
advance. This exclusion will not apply to drugs:
  - That have been granted investigational new drug (IND) treatment or Group 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 Claim Administrator has determined, based upon scientific evidence,
    demonstrate effectiveness or show promise of being effective for the disease. Refer to
    the Glossary for a definition of experimental, investigational or unproven services;

- Eyeglasses and contact lenses;

- 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 Claim Administrator;

- 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 Claim Administrator;
- 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 Plan does not cover charges for the freezing and storage of cryopreserved embryos, charges for storage of sperm;
- Inpatient private duty or special nursing care. Outpatient private duty nursing services must be pre-authorized by the Claim Administrator.
- 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. Please contact the plan for details. (These may not always be excluded.);
- 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, 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 Plan;

- 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, and diagnostic services 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 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 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 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 Claim Administrator;

- 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 Plan does 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 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 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 temporomandibular joint (TMJ) syndrome, including treatment performed by prosthesis placed directly on the teeth

- Weight reduction or control (unless there is a diagnosis of morbid obesity), special foods, food supplements, liquid diets, diet plans, or any related products.