Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
Effective Date: January 1, 2021

Eligibility Provision			
Employee	Regular full-time employees of an employer participating in this plan working a minimum of 20 hours per week.		
Dependent	Spouse, same or opposite sex domestic partner; children up to age 26, regardless of student status		
PPO Medical			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$0 per calendar year	$0 per calendar year	$500 per calendar year
Family Deductible	$0 per calendar year	$0 per calendar year	$1,000 per calendar year
Prior Plan Credit	Does not apply		
Individual Payment Limit	$1,000 per calendar year	$1,000 per calendar year	$3,000 per calendar year
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)			
Family Payment Limit	$2,000 per calendar year	$2,000 per calendar year	$6,000 per calendar year
(Does not include precertification penalty. Includes Outpatient Prescription Drugs when outside the US)			
Lifetime Maximum	Unlimited		
Member Payment Percentages			
Hospital Services			
Inpatient	15%	15%	30% after deductible
Outpatient	15%	15%	30% after deductible
Private Room Limit	The institution's semiprivate rate.		
Pre-certification Penalty	No Penalty	No Penalty	$500
Pre-Certification for certain types of Non-Preferred care received inside the U.S. must be obtained to avoid a reduction in benefits paid for that care. Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care and Hospice Care is required - excluded amount applied separately to each type of expense. Contact the service center to determine if pre-certification is needed for a procedure.			
Non-Emergency Use of the Emergency Room	15%	15%	30% after deductible
Emergency Room	15%	15%	15% no deductible
Non-Urgent Use of Urgent Care Provider	No Coverage	No Coverage	No Coverage
Urgent Care	15%	15%	15% after deductible
Physician Services			
Physician Office Visit	15%	15%	30% after deductible
Specialist Office Visit	15%	15%	30% after deductible

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		In the U.S.	
PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Mental Health Services*			
Mental Health Inpatient Coverage	15%	15%	30% after deductible
Unlimited days per calendar year			
Mental Health Outpatient Coverage	15%	15%	30% after deductible
Unlimited visits per calendar year			
Alcohol/Drug Abuse Services*			
Substance Abuse Inpatient Coverage	15%	15%	30% after deductible
Unlimited days per calendar year			
Substance Abuse Outpatient Coverage	15%	15%	30% after deductible
Unlimited visits per calendar year			
Prescription Drug Coverage			
Generic Drugs *(365 day maximum supply*	15%	15% per one month supply (includes Mail Order Drugs)	30% after deductible
Formulary Brand Name Drugs *(365 day maximum supply*	15%	15% per one month supply (includes Mail Order Drugs)	30% after deductible

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PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Preventive Benefits			
Routine Children Physical Exams	No charge	No charge	No charge
7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per 12 months thereafter to age 22 (includes immunizations)			
Routine Adult Physical Exams	No charge	No charge	No charge
Adults age 22+ & -65: 1 exam/12 months Adults age 65+: 1 exam/12 months includes immunizations			
Routine Gynecological Exams	No charge	No charge	No charge
Includes 1 exam and pap smear per calendar year			
Routine Mammograms	No charge	No charge	No charge
Prostate Specific Antigen (PSA)	No charge	No charge	No charge
Routine Digital Rectal Exam (DRE)	No charge	No charge	No charge
Colorectal Cancer Screening	No charge	No charge	30% no deductible
Recommended: For all members age 50 and over.			
Routine Hearing Exam	No charge	No charge	30% after deductible
Includes one routine exam every 24 months.			
Hearing Aids	15%	15%	30% after deductible
(Covers hearing aids to a maximum of $1,200. Adults; 36 months per ear and child 24 month per ear)			
Vision Care			
Routine Eye Exam	No charge	No charge	15% no deductible
(Covered under medical) Includes one routine exam every 12 months up to a $70 calendar year maximum)			
Vision Care Supplies	No charge	No charge	No charge
(Schedule maximum applies $200 every 12 months)			

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PLAN FEATURES	OUTSIDE THE U.S.	Preferred Benefits (In-Network)	Non-Preferred Benefits (Out-of-Network)
Other Services			
Skilled Nursing Facility *(120 days per calendar year)*	15%	15%	30% after deductible
Hospice Care Facility Inpatient *(30 days lifetime maximum)*	15%	15%	30% after deductible
Hospice Care Facility Outpatient *(Unlimited lifetime maximum)*	15%	15%	30% after deductible
Home Health Care *(120 visits per calendar year combined, includes Private Duty Nursing per calendar year)*	15%	15%	30% after deductible
Spinal Disorder Treatment *(20 visits per calendar year)*	15%	15%	25% after deductible
Short-Term Rehabilitation	15%	15%	30% after deductible
(Includes coverage for Occupational and Physical Therapies 60 visits combined maximum visits per calendar year, additional visits based on medical necessity)			
Speech Therapy	15%	15%	30% after deductible
(Includes coverage for Speech Therapies 90 visits combined maximum visits per calendar year, additional visits based on medical necessity)			
Diagnostic Outpatient X-ray	15%	15%	30% after deductible
Diagnostic Outpatient Lab	15%	15%	30% after deductible
Base Infertility Services	15%	15%	30% after deductible
(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)			
Comprehensive Infertility Services *($24,000 lifetime maximum combined)*	15%	15%	30% after deductible
(Comprehensive plan coverage includes coverage for Artificial Insemination and Ovulation Induction and Advanced Reproductive Technology (ART)			
Acupuncture	15%	15%	30% after deductible

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PPO Dental			
		In the U.S.	
PLAN FEATURES	**OUTSIDE THE U.S.**	**Preferred Benefits (In-Network)**	**Non-Preferred Benefits (Out-of-Network)**
Individual Deductible	$75 per calendar year	$75 per calendar year	$75 per calendar year
Family Deductible	$225 per calendar year	$225 per calendar year	$225 per calendar year
Type A Expense *(Diagnostic & Preventive)*	No charge	No charge	No charge
Type B Expense *(Basic Restorative)*	20% after deductible	20% after deductible	20% after deductible
Type C Expense *(Major Restorative)*	50% after deductible	50% after deductible	50% after deductible
Calendar Year Maximum	$2,000	$2,000	$2,000
Orthodontic Treatment Coverage for Adults and Dependent	50%	50%	50%
Orthodontic Lifetime Maximum	$2,000	$2,000	$2,000
Please refer to the Dental Plan Caveats below for additional benefit coverages for Types A, B and C			

Other Services			
Emergency Assistance Program *(Unlimited calendar year maximum)*	No charge	No charge	No charge
Employee Assistance Program (EAP)	Included	Included	Included
Includes up to 5 counseling sessions per issue per year per enrolled member. Access benefits by calling the member service number on ID card: 800-231-7729 or collect 813-775-0190. Services include: Cultural adjustment assistance, Marital/Family Stress, Child care and behavioral concerns, Social adaptation needs, Alcohol/Substance Abuse, Work/Life Balance and Depression.			
In Touch Care (ITC)	Included	Included	Included
International Maternity Management Program	Included	Included	Included
24-Hour Nurse Line	Included	Included	Included
Health Assessment	Included	Included	Included

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Medical Plan Caveats
This plan includes coverage for women's preventive and other preventive health benefits to the extent required under the Affordable care act beginning with plan years starting on or after August 1, 2012.
Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage, deductibles and copays may be used to satisfy the payment limit. Precertification penalty are excluded from the payment limit. *There is cross-application between calendar year deductible, out of pocket maximum and lifetime maximum across overseas, in-network and out-of-network level of benefits.* *Coverage maximums up to a certain number of days/visits per calendar year are reached by combining the Preferred and Non-Preferred benefits up to the limit for either one plan or the other, but not both. (Example, if the Preferred benefit is for 120 days and the Non-Preferred benefit is for 120 days, the maximum benefit is 120 days, not 240 days).* *Maternity expenses are covered as any other medical expense. Coverage is provided for an employee and spouse and all female family members Pregnancy benefits do not continue to be payable after coverage ends except in the event of total disability.* *For contracted hospitals, the non-contracted Radiologist, Anesthesiologist and Pathologist (RAPS) are paid at the preferred level, and will be subject to reasonable and customary charges. Note that this payment method may apply to other providers.* *Benefit maximums per Calendar year are calculated between 01/01/2021 and 12/31/2021.* ***Other Health Care (Out-of-Area):*** *When care is provided in the U.S. in a geographic area in which Aetna has not contracted with a provider, charges are payable at 80% after any applicable Deductible (does not apply to those expenses paid at a reduced payment percentage). The benefit levels associated with the following In-Network provisions would apply: Deductible, Family Deductible, Inpatient Hospital Deductible, Out of-pocket maximum(s).* **This plan includes coverage under the extent required in accordance with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) beginning with plan years starting on or after January 1, 2018.* *This plan includes coverage for women's preventive health benefits to the extent required under U.S. federal law effective beginning with plan years starting on or after August 1, 2012.* *Payment limits apply per individual on a calendar year basis. Only those out-of-pocket expenses resulting from the application of a payment percentage may be used to satisfy the payment limit. Deductibles, copays, benefit penalties and 50% items are excluded from the payment limit.*

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Dental Plan Caveats
Dental PPO   **Type A**   *Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.*   **Type B**   *Includes Fillings, Simple Extractions and Oral Surgery.*   **Type C**   *Includes Crown Lengthening, Crown Buildup, Inlays/onlays, Bridgework, Osseous surgery, Soft tissue grafts, Partial and full bony impactions, General anesthesia and intravenous sedation, Dentures (benefit includes all relines, rebases and adjustments within 6 months of installation), Molar root canal therapy, Prosthetic repairs, and Occlusal Guards (for bruxism only).*   *Bases and adjustments within 6 months of installation), Prosthetic repairs, and Occlusal Guards (for bruxism only).*

This is only a brief summary of the PPO Medical, PPO Dental benefits available. Some restrictions may apply.

*For more specific information about the coverage details, **including limitations, exclusions and other plan requirements**, please refer to the employee booklet*

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For Plans Compliant with United States Federal Affordable Care Act (ACA) legislation
Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779), 1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

English	**To access language services at no cost to you, call the number on your ID card.**
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.

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Persian Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.