**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.healthreformplanSBC.com or by calling 1-800-231-7729.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | For in-network **providers** **$0** person/ **$0** family<br>For out-of-network **providers** **$500** person/ **$1,000** family<br>Doesn't apply to preventive care | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**. |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out–of–pocket limit on my expenses?** | Yes. For in-network **providers** **$1,000** person/ **$2,000** family<br>For out-of-network **providers** **$3,000** person/ **$6,000** family | The **out–of–pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out–of–pocket limit?** | Penalties for failure to obtain pre-authorization for services, premiums, balanced-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out–of–pocket limit**. |
| **Is there an overall annual limit on what the plan pays?** | No. | The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services such as office visits. |
| **Does this plan use a network of providers?** | Yes. See www.aetna.com or call 1-800-231-7729 for a list of in-network **providers**. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**. |
| **Do I need a referral to see a specialist?** | No. You don't need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**. |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Specialist visit | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Other practitioner office visit | 15% coinsurance for chiropractor | 25% coinsurance for chiropractor | 60 visits per calendar year combined with Short Term |
| | Preventive care/screening/immunization | No Charge | No Charge | ——————none—————— |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 15% coinsurance | 30% coinsurance | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you need drugs to treat your illness or condition**<br><br>More information about **prescription drug coverage** is available at: www.aetna.com/pharmacy-insurance/individuals-families | Generic drugs | 15% copay/31-day supply<br>15% copay/ 90-day supply mail-order | 30% coinsurance | Covers 365-day supply (with provider approval) |
| | Preferred brand drugs | 15% copay/31-day supply<br>15% copay/ 90-day supply mail-order | 30% coinsurance | Covers 365-day supply (with provider approval) |
| | Non-preferred brand drugs | 15% copay/31-day supply<br>15% copay/ 90-day supply mail-order | 30% coinsurance | Covers 365-day supply (with provider approval) |
| | Specialty drugs | 15% copay/31-day supply | 30% coinsurance | ——————none—————— |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Physician/surgeon fees | 15% coinsurance | 30% coinsurance | ——————none—————— |
| **If you need immediate medical attention** | Emergency room services | 15% coinsurance | 15% coinsurance | ——————none—————— |
| | Emergency medical transportation | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Urgent care | 15% coinsurance | 15% coinsurance | ——————none—————— |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 15% coinsurance | 30% coinsurance | ——————none—————— |
| | Physician/surgeon fee | 15% coinsurance | 30% coinsurance | ——————none—————— |

| Common Medical Event | Services You May Need | Your Cost If You Use an In-Network Provider | Your Cost If You Use an Out-Of-Network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 15% coinsurance | 30% coinsurance | Unlimited visits per calendar year |
| | Mental/Behavioral health inpatient services | 15% coinsurance | 30% coinsurance | Unlimited days per calendar year |
| | Substance use disorder outpatient services | 15% coinsurance | 30% coinsurance | Unlimited visits per calendar year |
| | Substance use disorder inpatient services | 15% coinsurance | 30% coinsurance | Unlimited days per calendar year |
| **If you are pregnant** | Prenatal and postnatal care | No Charge | 30% coinsurance | ——————none—————— |
| | Delivery and all inpatient services | 15% coinsurance | 30% coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 15% coinsurance | 30% coinsurance | 120 visits per calendar year |
| | Rehabilitation services | 15% coinsurance | 30% coinsurance | 60 visits per calendar year combined with Spinal Manipulation |
| | Habilitation services | 15% coinsurance | 30% coinsurance | 60 visits per calendar year combined with Spinal Manipulation |
| | Skilled nursing care | 15% coinsurance | 30% coinsurance | 120 visits per calendar year |
| | Durable medical equipment | 15% coinsurance | 30% coinsurance | Unlimited Lifetime Maximum |
| | Hospice service | 15% coinsurance | 30% coinsurance | Inpatient: 30 days<br>Outpatient: Unlimited visits |
| **If your child needs dental or eye care** | Eye exam | No Charge | 15% coinsurance | 1 exam every 12 months up to $70 calendar year maximum |
| | Glasses | No Charge | No Charge | Schedule maximums $200 apply every 12 months. |
| | Dental check-up | Not Covered | Not Covered | Not Covered |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other **excluded services**.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Children)
- Long-term care

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture
- Chiropractic care
- Glasses
- Hearing aids
- Infertility treatment
- Most coverage provided outside of United States. See www.aetnainternational.com
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care - when treatment is required due to disease or injury
- Weight loss programs

## Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-231-7729. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Aetna at 1-800-231-7729, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

A state department of insurance and/or consumer assistance program may also be able to help you file an appeal. Contact information is at http://www.aetna.com/individuals-families-health-insurance/member-guidelines/complaints-grievances-appeals.html

## Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

## Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

## Language Access Services:

Para obtener asistencia en Español, llame al 1-800-231-7729.
Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-231-7729.
**如果需要中文的帮助**，请拨打这个号码 1-800-231-7729.
Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-231-7729.

*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

**Amount owed to providers:** $7,540
- **Plan pays** $6,610
- **Patient pays** $930

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $0 |
| Co-pays | $0 |
| Co-insurance | $780 |
| Limits or exclusions | $150 |
| **Total** | **$930** |

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

**Amount owed to providers:** $5,400
- **Plan pays** $4,630
- **Patient pays** $770

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $60 |
| Co-pays | $0 |
| Co-insurance | $630 |
| Limits or exclusions | $80 |
| **Total** | **$770** |

# Questions and answers about the Coverage Examples:

## What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

## What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles, co-payments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

## Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

## Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

## Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

## Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments, deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| 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% no deductible |
| ***Physician Services*** | | | |
| **Physician Office Visit** | 15% | 15% | 30% after deductible |
| **Specialist Office Visit** | 15% | 15% | 30% after deductible |

This is supplemental summary information. For more summary information, see the corresponding Summary of Benefits and Coverage (SBC) document. These documents are only a summary and are not plan documents. Please see your plan documents for comprehensive information on the plan's coverage, and other limitations.

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International® Effective Date: January 1, 2017

| PPO Medical | | | |
|---|---|---|---|
| | | 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 |
| *Other Services* | | | |
| **International Employee Assistance Program (IEAP)** | 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.* | | | |

This is supplemental summary information. For more summary information, see the corresponding Summary of Benefits and Coverage (SBC) document. These documents are only a summary and are not plan documents. Please see your plan documents for comprehensive information on the plan's coverage, and other limitations.

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International® Effective Date: January 1, 2017

| PPO Medical | | | |
|---|---|---|---|
| | | In the U.S. | |
| 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)* | | | |

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
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| PPO Medical | | | |
|---|---|---|---|
| | | In the U.S. | |
| 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** *(60 visits per calendar year combined with Occupational, Physical. Speech Therapies )* | 15% | 15% | 25% after deductible |
| **Short-Term Rehabilitation** | 15% | 15% | 30% after deductible |
| *(Includes coverage for Occupational, Physical, Speech Therapies and Spinal Manipulation; 60 visits combined maximum visits per calendar year)* | | | |
| **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)* | | | |
| **Acupuncture** | 15% | 15% | 30% after deductible |

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International® Effective Date: January 1, 2017

| 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* | | | |

| Group Insurance |
|---|
| The maximum amount shown in the grid below is the maximum amount payable for any combination of Life and Accidental Death and Personal Loss benefits. |

| Services and Programs included in Quote |
|---|
| **Informed Health Line (24-hour nurse line)** |
| **Cobra** |
| **Health Care Management Programs** |
| **International Maternity Management Program** |
| **Simple Steps To A Healthier Life®** |
| **Wellness Checkpoint** |
| **On-Line Global Health and Travel Information through HTH Worldwide (http//www.aetnainternational.com)** |

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| 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.* |

| Dental Plan Caveats |
| --- |
| ***Dental PPO***<br><br>**Type A**<br>*Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.*<br><br>**Type B**<br>*Includes Fillings, Simple Extractions and Oral Surgery.*<br><br>**Type C**<br>*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).*<br>*Bases and adjustments within 6 months of installation), Prosthetic repairs, and Occlusal Guards (for bruxism only).* |

*The proposed plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).*

*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 (which will be provided near the time the plan becomes effective).*

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International® Effective Date: January 1, 2017

| | | | |
|---|---|---|---|
| **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** | None | None | $500 per calendar year |
| **Family Deductible** | None | None | $1,000 per calendar year |
| **Prior Plan Credit** | Does not apply | | |
| **Individual Payment Limit** | None | $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** | None | $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** | No charge | 15% after deductible | 30% after deductible |
| **Outpatient** | No charge | 15% after deductible | 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** | No charge | 15% after deductible | 30% after deductible |
| **Emergency Room** | No charge | 15% after deductible | 15% after deductible |
| **Non-Urgent Use of Urgent Care Provider** | No coverage | No coverage | No Coverage |
| **Urgent Care** | No charge | 15% after deductible | 15% after deductible |
| ***Physician Services*** | | | |
| **Physician Office Visit** | No charge | 15% after deductible | 30% after deductible |
| **Specialist Office Visit** | No charge | 15% after deductible | 30% after deductible |

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| PPO Medical | | | |
|---|---|---|---|
| | | 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** | No charge | 15% after deductible | 30% after deductible |
| *Unlimited days per calendar year* | | | |
| **Mental Health Outpatient Coverage** | No charge | 15% after deductible | 30% after deductible |
| *Unlimited visits per calendar year* | | | |
| *Alcohol/Drug Abuse Services* | | | |
| **Substance Abuse Inpatient Coverage** | No charge | 15% after deductible | 30% after deductible |
| *Unlimited days per calendar year* | | | |
| **Substance Abuse Outpatient Coverage** | No charge | 15% after deductible | 30% after deductible |
| *Unlimited visits per calendar year* | | | |
| *Prescription Drug Coverage* | | | |
| **Generic Drugs** *(365 day maximum supply* | No charge | 15% per one month supply (includes Mail Order Drugs) | 30% after deductible |
| **Formulary Brand Name Drugs** *(365 day maximum supply* | No charge | 15% per one month supply (includes Mail Order Drugs) | 30% after deductible |
| *Other Services* | | | |
| **International Employee Assistance Program (IEAP)** | 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.* | | | |

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# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| PPO Medical | | | |
|---|---|---|---|
| | | In the U.S. | |
| 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** | No charge | 15% after deductible | 30% after deductible |
| *Covers hearing aids to a maximum of $1,200. Adults - every 36 months per ear and child - every 24 months 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)* | | | |

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| PPO Medical | | | |
|---|---|---|---|
| | | In the U.S. | |
| 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)* | No charge | 15% after deductible | 30% after deductible |
| **Hospice Care Facility Inpatient** *(30 days lifetime maximum)* | No charge | 15% after deductible | 30% after deductible |
| **Hospice Care Facility Outpatient** *(Unlimited lifetime maximum)* | No charge | 15% after deductible | 30% after deductible |
| **Home Health Care** *(120 visits per calendar year combined, includes Private Duty Nursing per calendar year)* | No charge | 15% after deductible | 30% after deductible |
| **Spinal Disorder Treatment** *(60 visits per calendar year combined with Occupational, Physical and Speech Therapies )* | No charge | 15% after deductible | 25% after deductible |
| **Short-Term Rehabilitation** | No charge | 15% after deductible | 30% after deductible |
| *(Includes coverage for Occupational, Physical and Speech Therapies and Spinal Manipulation; 60 visits combined maximum visits per calendar year)* | | | |
| **Diagnostic Outpatient X-ray** | No charge | 15% after deductible | 30% after deductible |
| **Diagnostic Outpatient Lab** | No charge | 15% after deductible | 30% after deductible |
| **Base Infertility Services** | No charge | 15% after deductible | 30% after deductible |
| *(Base plan coverage includes coverage limited to the testing and treatment of underlying condition)* | | | |
| **Acupuncture** | No charge | 15% after deductible | 30% after deductible |

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| 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* | | | |

This is supplemental summary information. For more summary information, see the corresponding Summary of Benefits and Coverage (SBC) document. These documents are only a summary and are not plan documents. Please see your plan documents for comprehensive information on the plan's coverage, and other limitations.

# Group Insurance Plan of Benefits for Citigroup (Control 706365) administered by Aetna International®
# Effective Date: January 1, 2017

| Services and Programs included in Quote |
|---|
| Informed Health Line (24-hour nurse line)<br>Cobra<br>Health Care Management Programs<br>International Maternity Management Program<br>Simple Steps To A Healthier Life®<br>Wellness Checkpoint<br>On-Line Global Health and Travel Information through HTH Worldwide (http//www.aetnainternational.com) |

| 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.* |

| Dental Plan Caveats |
| --- |
| ***Dental PPO***<br><br>**Type A**<br>*Includes Prophylaxis, Bitewing and full mouth series X-rays, Space Maintainers, Oral Exams, Fluoride applications, Sealants, and Periapical X-rays.*<br><br>**Type B**<br>*Includes Fillings, Simple Extractions and Oral Surgery.*<br><br>**Type C**<br>*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).* |

*The proposed plan of benefits is underwritten by Aetna Life Insurance Company (Delaware).*

*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.*