

BENEFITS 2006: CHOOSING YOUR CITIGROUP BENEFITS

Puerto Rico edition

Citigroup offers a variety of health and insurance benefits so you can customize a comprehensive program that fits your needs. The enclosed materials describe the health and insurance benefits available in 2006.

If you need information about benefits coverage that isn't included in this book, contact the health plans directly as explained in the "Telephone and Web site directory" on page 7 or call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and follow the prompts for the Benefits Service Center. You can choose to hear the enrollment menu in Spanish or in English. Representatives are available from 6 a.m. to 11:45p.m. Eastern time on weekdays, excluding holidays.

Contents

Important information about the contents of this document.....	5
Telephone and Web site directory	7
Instructions.....	8
What happens if you don't enroll.....	8
How to enroll	8
Benefits overview	8
Confirmation of enrollment	9
Confirmation of default.....	9
Beneficiary forms.....	9
Eligibility	10
Definition of eligible dependents.....	10
Paying for your benefits.....	11
Total compensation.....	11
For Smith Barney financial consultants and Global Consumer financial executives of CBNA	12
Coordination of benefits	12
How coordination of benefits works.....	13
Coverage categories.....	13
Qualified changes in status	14
Reporting a qualified change in status event	14
Changing your coverage category	15
Change in Status Worksheet.....	15
Deadline to report qualified changes in status	15
Plan changes you can make at any time.....	15
Domestic partner benefits	16
When you can enroll your domestic partner in Citigroup coverage.....	16
Eligibility	16
Maternity benefits.....	18
Qualified Medical Child Support Orders (QMCSOs)	18
Medical	19
Triple-S PPO.....	19
Preventive care.....	19
Infertility	20
Additional medical plan information	21
Prescription drugs	21
Mental health and substance abuse benefits	24
Precertification.....	24
Dental.....	24
Basic Dental.....	25
Comprehensive Dental.....	25
Vision Care Plan	26
Vision Care Plan features.....	26

Network benefits.....	26
Out-of-network benefits.....	27
Definition of medical necessity	27
Low vision	27
Health care ID cards.....	28
Disability.....	28
Short-Term Disability (STD).....	28
Long-Term Disability (LTD).....	30
Life insurance benefits.....	31
Basic Life/AD&D insurance.....	31
Optional GUL/Supplemental AD&D insurance	32
Coverage for your spouse/domestic partner	34
Coverage for your children	34
Business Travel Accident insurance.....	35
Long-Term Care (LTC) insurance.....	35
Glossary	42
Legal and administrative information.....	43
When coverage ends	43
Coverage for surviving dependents	43
Coverage if you become disabled.....	44
Coverage if you take a leave of absence.....	45
Continuing coverage during an FMLA leave	45
Continuing coverage during a military leave.....	45
Notice of HIPAA Privacy Practices.....	46
COBRA.....	53
Recovery provisions.....	58
Claims and appeals	61
ERISA information	61
Administrative information.....	63
Plan information.....	65

Important information about the contents of this document

This document describes health and welfare benefits for certain Puerto Rico employees of Citigroup Inc. (“Citigroup”) and its participating companies (collectively the “Company”), as in effect January 1, 2006. The benefits described in this document are:

- Citigroup Medical Plans
 - Triple-S Preferred Provider Organization (PPO) Plan and
 - Citigroup Prescription Drug Program.

- Citigroup Dental Plans
 - Triple-S Dental Plan

- Citigroup Vision Care Plan;
- Citigroup Short-Term Disability Plan;
- Citigroup Long-Term Disability Plan;
- Citigroup life insurance benefits
 - Basic Life Insurance and Accidental Death and Dismemberment (AD&D) and
 - Optional Group Universal Life Insurance and Supplemental AD&D.¹

The document serves as a summary plan description (SPD) for the health and welfare benefit plans described above (the “Citigroup Health and Welfare Plans or collectively the “Plans” and individually a “Plan”).

This summary has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the Plans as they are in effect. This description is intended only to be a summary of the major highlights of the Plans.

No general explanation can adequately give you all the details of the Plans. This general explanation does not change, expand, or otherwise interpret the terms of the Plan. If there’s any conflict between this SPD and the Plan documents (including any related insurance contracts), the terms of the Plan documents — including any related insurance contracts — will be followed in determining your rights and benefits under the Plans.

The Plans are subject to the Internal Revenue Code of 1986, as amended (the “IRC”). With the exception of Optional Group Universal Life and Supplemental AD&D, the Plans are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). To the extent applicable, the Plans will be interpreted and administered in accordance with the IRC, ERISA, and applicable law.

Citigroup may change or discontinue the Plans or any part thereof at any time without notice.

¹ While many of these benefits are provided under employee benefit arrangements sponsored by Citigroup, the optional GUL insurance coverage above is offered solely as a convenience to Citigroup employees and isn’t endorsed by the Company.

This document is neither a contract nor a guarantee of continued employment for any definite period of time. Your employment is always on an at-will basis.

This document includes summary information about the federal tax treatment of employee benefits. The summary information is general in nature and isn't meant as tax advice. Citigroup Inc. and its affiliates are not in the business of providing personal tax or legal advice to its employees. Any such taxpayer should seek advice based on the taxpayer's particular circumstances from an independent tax adviser.

Telephone and Web site directory

You can contact many of the vendors through the “health and welfare benefits” option of ConnectOne.

<p>Benefits Service Center Available by choosing the health benefits option of ConnectOne</p> <p>For plan information and to enroll, visit the Internet</p>	<p>1-800-881-3938 1-972-652-4582 (from outside the United States and Puerto Rico) 1-800-845-8531 (TDD) https://mybenefits.csplans.com</p>
<p>Consolidated Omnibus Budget Reconciliation Act (COBRA)</p>	<p>1-800-422-7608</p>
<p>Dental Triple-S</p>	<p>1-787-749-4777 www.ssspr.com</p>
<p>Life/Accidental Death and Dismemberment (AD&D) insurance Benefits Service Center; available by choosing the health benefits option of ConnectOne</p>	<p>1-800-881-3938</p>
<p>Long-Term Care insurance John Hancock Life Insurance Co.</p>	<p>1-800-222-6814 http://groupplc.jhancock.com User name: groupplc Password: mybenefit</p>
<p>Long-Term Disability (LTD) and Short-Term Disability (STD) Benefits Service Center; available by choosing the “health and welfare benefits” option of ConnectOne</p>	<p>1-800-881-3938</p>
<p>Medical Triple-S</p>	<p>1-787-749-4777 www.ssspr.com</p>
<p>Prescription Drug Program AdvancePCS</p>	<p>1-800-390-6441 www.advancerx.com</p>
<p>Total Compensation Web site</p>	<p>https://www.totalcomponline.com</p>
<p>Vision Care Plan Davis Vision</p>	<p>1-800-999-5431 www.davisvision.com</p>

Instructions

Review your benefits materials, in particular your Personal Enrollment Worksheet, which lists the cost of coverage, your enrollment instructions, and enrollment deadline.

- If you want to enroll in Citigroup coverage, you *must* enroll during your enrollment period.
- If applicable, call to confirm that a network provider will continue in the Plan's network next year.
- You must actively enroll within 31 days of your date of hire or date of eligibility.

What happens if you don't enroll

If you don't enroll for 2006, you must wait until the next annual enrollment period or you have a qualified change in status to enroll in medical, dental, vision, or Long-Term Disability coverage. See page 14 for information on qualified changes in status.

How to enroll

You can link to the Citigroup Benefits Web Site by visiting Total Comp at Citigroup at <https://www.totalcomponline.com>.

You also can enroll by telephone. Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center. Your enrollment deadline is available online or on your Personal Enrollment Worksheet

Benefits overview

Citigroup provides a basic level of benefits coverage (core benefits) as well as the opportunity to enroll in additional coverage.

Core benefits, provided at no cost to you, are:

- Basic Life insurance that includes Accidental Death and Dismemberment (AD&D) insurance, each equal to your total compensation, up to \$200,000, on your date of eligibility.
- Short-Term Disability (STD) coverage to replace up to 100% of your annual base salary for an approved disability leave of up to 13 weeks. The number of weeks at 100% pay will depend on your length of service with Citigroup. See page 17 for the STD schedule of benefits.
- Long-Term Disability (LTD) coverage equal to 60% of your total compensation if your total compensation is less than or equal to \$50,000.99; if your total compensation is \$50,001 and above and you want to enroll in LTD coverage, you must pay for it.

Additional benefits, which you'll want to consider based on your individual and family circumstances, include:

- Medical;
- Dental;
- Vision care;
- Long-Term Disability (LTD), if your total compensation is \$50,001 and above. **Note:** If your total compensation is \$50,000.99 and under, LTD is a core benefit provided at no cost to you;

- Group Universal Life (GUL) insurance and Accidental Death and Dismemberment (AD&D) insurance; and
- Long-Term Care insurance.

Confirmation of enrollment

If you enroll by telephone, a confirmation statement will be mailed to your home between one and three weeks after you enroll. Your confirmation statement will list your benefit elections for 2006 and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment.

If you need to use a medical provider (doctor or hospital) before you receive your health plan ID card, use your confirmation statement as proof of 2006 coverage along with the Triple-S group number (1-03450).

If you enroll online, you won't receive a confirmation statement in the mail. Instead, print the confirmation screen after you enroll. Your screen print will serve as a confirmation that you've enrolled.

Confirmation of default

If you don't enroll, you'll receive a default statement within several weeks after your enrollment deadline. The default statement will list your 2006 Citigroup benefits (if any) that will continue through 2006 and their costs. Retain this statement as proof of any 2006 coverage you may have.

If you'll have medical coverage for 2006 and need to use a medical provider (doctor or hospital) before you receive your health plan ID card, use your confirmation statement as proof of 2006 coverage along with the Triple-S group number (1-03450).

Beneficiary forms

Your beneficiary information should be on file with Citigroup. If you've never designated a beneficiary (either by completing a form or visiting the Your Benefits Resources™ Web site, you should visit <http://resources.hewitt.com/citigroup/> or link to Your Benefits Resources through the Total Comp at Citigroup at <https://www.totalcomponline.com>.

You also can call ConnectOne at 1-800-881-3938. From the main menu, choose the "pension and retiree health and welfare" option. Then choose the "beneficiary" option.

If you enroll in Optional GUL insurance for the first time, you must complete a MetLife Beneficiary Designation-Form 201 available at http://www.citigroup.net/human_resources/form.htm and return it to MetLife at the address on the form.

If you change your beneficiary designation for either Basic Life or Optional GUL, it won't automatically apply to the other Plan. You must change the beneficiary for each Plan separately.

If you retire, the beneficiary you designated while an employee will be carried over to any Company-provided retirement policies you may have until you designate other beneficiaries.

Eligibility

You're eligible to enroll in Citigroup benefits and to receive company-provided core benefits if you're an active benefits-eligible employee of Citigroup or its affiliates. If you're on an approved leave of absence, you're also eligible to enroll in Citigroup benefits other than Long-Term Care insurance. Other enrollment restrictions may apply.

If both you and your spouse/domestic partner are employed by Citigroup, each of you can enroll individually or one of you can enroll and claim the other as a dependent. However, you can't enroll as an individual *and* be claimed as your spouse's dependent.

Definition of eligible dependents

- Your lawfully married spouse; if you're legally separated, your spouse *isn't* an eligible dependent;
- Your domestic partner; see "Domestic partner benefits" beginning on page 16 for details;
- Your domestic partner's eligible dependents; see "Domestic partner benefits" beginning on page 16 for details;
- Your unmarried children who rely on you for financial support and are:
 - Your biological children;
 - Your legally adopted children;
 - Your stepchildren; or
 - Other children who are permanently living with you in a regular parent-child relationship (or who live away at school) and who are primarily dependent on you for financial support and for whom you have guardianship.

You can cover your children if they are:

- Under the age of 19; or
- Under the age of 25² and attend an accredited school or college full time (according to the school's or college's definition of full time); *you must provide proof of student status in writing upon request*; or
- Handicapped in which case they may be eligible for coverage beyond age 25; handicapped children are eligible for coverage beyond age 25 only if they had Citigroup coverage prior to age 25.

During your enrollment, you'll be prompted to certify that your eligible child is a student according to the definition above. In addition, at the start of each semester (August 1 and January 1), you'll be required to provide student certification documentation to Triple-S by September 1 and February 1. If appropriate documentation isn't received, the student's coverage will be terminated September 1 or February 1.

No dependent can be covered under these plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee.

² Coverage will be terminated at the end of the year in which the child turns 25, if he/she continues to be a full-time student.

Refer to the Long-Term Care section for specific dependent eligibility under that Plan.

Paying for your benefits

In addition to paying for core benefits, Citigroup contributes toward the cost of medical and dental coverage for you and your dependents. You'll find the cost to enroll in all coverage categories on your Personal Enrollment Worksheet.

Your contribution for medical coverage will depend on the amount of your total compensation and your coverage category.

Total compensation

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- Optional GUL/Supplemental AD&D insurance and costs; and
- STD for financial consultants in Global Wealth Management.

If you're enrolling in benefits as a new hire or newly eligible employee: Your total compensation at the time you're hired is equal to your annualized salary plus shift differential. If you're paid on commissions only, your total compensation is calculated differently. Consult your HR representative.

For future years, your total compensation will be based on a formula that includes your actual base pay plus shift differential, commissions, performance-based bonuses, and annual incentive bonus.

If you're enrolling during the annual enrollment period for coverage effective January 1, 2006: Your Total Compensation for 2006 will be calculated using the following components as they apply to you:

1. Annual base pay as of July 1 in the year of enrollment

Example: Annual base pay as of July 1, 2005, will be used for 2006 annual enrollment calculations.

2. Commissions paid from January 1- December 31 in the year prior to enrollment to capture an entire year of commissions paid.

Example: Commissions paid from January 1-December 31, 2004, will be used for 2006 annual enrollment calculations.

3. Cash bonus (other than the cash portion of any annual discretionary award package) paid in the period January 1-December 31 in the year prior to enrollment.

Example: Cash bonuses paid in the period January 1-December 31, 2004 (excluding the cash portion of the annual discretionary award package dated January, 2004) will be used for 2006 annual enrollment calculation.

4. Annual discretionary award package dated in the year of enrollment (includes the following if applicable: cash bonus; CAP Basic Award; and, only for employees with discretionary award packages valued at \$500,000 and above, Supplemental CAP award).

Example: Annual discretionary award packages dated January, 2005 will be used for 2006 annual enrollment calculations.

For Smith Barney financial consultants and Global Consumer financial executives of CBNA

In your first year of employment, your total compensation is considered to be \$60,000. If you earned more than \$60,000 at a previous brokerage firm in the prior year and want your insurance coverage to represent your prior earnings, you can, but don't have to, provide a copy of your previous year's Form W-2PR Wage and Tax Statement to your HR representative within 30 days of your hire date. Providing a copy of your previous year's Form W-2PR is optional.

Your Basic Life insurance amount will be set at the higher amount (up to \$200,000). In addition, your medical contributions, Optional GUL amount, and LTD benefits and contributions (if applicable) also will be based on the higher amount.

Your decision whether to have your total compensation set at \$60,000 or your actual amount is irrevocable, once made.

Coordination of benefits

Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citigroup Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Medical Plan and the Citigroup Dental Plan contain a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the Plan documents.

When you're covered by more than one plan, the primary plan will pay benefits first while the secondary plan will pay benefits after the primary plan has paid benefits.

How coordination of benefits works

- **When the Citigroup Plan is primary:** The Citigroup Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first.
- **When the Citigroup Plan is secondary:** The Citigroup Plan will pay the difference, if any, between what you would've received from Citigroup if it were the only coverage and what you're eligible to receive from the other plan. *Total benefits will never equal more than what the Citigroup Plan would have paid alone.* When the Citigroup Plan is secondary and the patient is covered under an HMO, benefits under the Citigroup Plan will be limited to the copayment, if any, for which you would've been responsible under the HMO whether or not the services provided are rendered by the HMO.

The Citigroup Plan will be the primary plan for claims:

- For you, if you aren't covered as an employee by another plan;
- For your spouse, if your spouse isn't covered as an employee by another plan; and
- For your dependent children

Parents' birthdays are used to determine whose coverage is primary for the children. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage. For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is considered the primary plan for your children.

If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

In case of divorce or separation

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

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent who does not have custody of the child.

In the event of a legal conflict between two plans over which is primary and which is secondary, the plan that has covered the individual for the longer time will be considered primary. When a plan doesn't have a coordination-of-benefits provision, the rules in this provision aren't applicable and such plan's coverage is automatically considered primary.

Coverage categories

Citigroup offers four coverage categories from which you may choose to enroll for medical and dental coverage:

- Employee only: Coverage for you only;

- Employee plus spouse/domestic partner: Coverage for you and your spouse only;
- Employee plus child(ren): Coverage for you and your eligible child(ren); and
- Employee plus family: Coverage for you, your spouse, and your eligible child(ren).

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status.

Qualified changes in status

You must report to Citigroup any change of status that affects your benefits within 31 days of the qualified change by following the process described under “How to report a qualified change in status event” below. Don’t report qualified changes in status to your medical Plan. Your medical Plan must receive any status changes from Citigroup, not from you.

Depending on the event, you can enroll in or cancel your medical, dental, vision care, LTD, Optional GUL/Supplemental AD&D coverage.

Examples of qualified changes in status are:

- Your marriage, legal separation, or divorce;
- Meeting the eligibility to qualify as a domestic partner;
- The birth or adoption of a child;
- The loss of coverage eligibility for a dependent child who gets married, obtains a full-time job, or recovers from a disability;
- The loss of coverage under your spouse’s/domestic partner’s other employer’s plan;
- The death of a spouse/domestic partner or dependent child;
- The issuance of a qualified medical child support order (QMCSO); and
- Relocation outside your medical and/or dental plan’s network area.

Reporting a qualified change in status event

You have 31 days from the day of the event to report the name, date of birth, and Social Security number (if available) for the dependent(s) you want to add or remove from your coverage. If you’re adding a newborn who doesn’t yet have a Social Security number, you can report all other information within 31 days and report the Social Security number when you obtain it.

You must also report a new dependent even if you’re already enrolled in Citigroup family medical and dental coverage. Without dependent information on file, your new dependent’s claims *won’t* be paid even if you already have family coverage.

To report a qualified change in status:

- Call ConnectOne at 1-800-881-3938. From the main menu, choose the “health and welfare benefits” option. From the Benefits Service Center main menu, choose the option to change your coverage for the current year. You can report most changes by following the prompts. However, you must speak with a representative to report a divorce or the death of a dependent.
- Visit Total Comp at Citigroup at <https://www.totalcomponline.com> and link to the Citigroup Benefits Web Site.

Changing your coverage category

When reporting a new dependent that you want to cover, you may have to change your coverage category. For example, if you're enrolled in medical coverage under the "Employee only" category and then you get married and want to cover your new spouse, you'd have to report your new spouse *and* change from "Employee only" to the "Employee plus spouse" coverage category. A change from "Employee only" to any other coverage category will cost more money.

Remember, you must report the addition of a dependent even if you already have family coverage; otherwise, your new dependent won't be covered and his or her claims won't be paid.

Change in Status Worksheet

You can review the Change in Status Worksheet-Form 308, which lists status events and the corresponding changes you can make to your benefits coverage for each event. To obtain a Change in Status Worksheet, visit the "Forms" section of the You @ Citigroup site at www.citigroup.net/human_resources.

Deadline to report qualified changes in status

You must report or revise dependent information and change your coverage or coverage category, if necessary, within 31 days of the date of the qualified change in status. Otherwise, you won't be able to change your coverage or coverage category until the next annual enrollment period or until you have another change in status event, whichever comes first.

Plan changes you can make at any time

You can cancel, enroll in, or change the following coverage at any time.

- LTD: You can enroll at any time but you must provide evidence of good health. However, unless you were enrolled in a prior employer's group plan three months prior to your hire date at Citigroup, the disability Plan won't cover any total disability caused by, contributed to, or resulting from a pre-existing condition until you've been enrolled in the Plan for 12 consecutive months. A pre-existing condition is an injury, sickness, or pregnancy for which — in the three months prior to the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.
- Optional GUL/AD&D: For the GUL portion of the benefit, MetLife will require evidence of good health if you want to:
 - Enroll for the first time (other than during your initial enrollment period as a new hire or newly eligible for Citigroup benefits);
 - Increase your coverage amount;**Note:** CIGNA administers the AD&D portion of the benefit and doesn't require evidence of good health.
- Long-Term Care insurance: If you enroll at any time other than your initial enrollment period as a new hire, John Hancock will require evidence of good health before coverage will be approved

Domestic partner benefits

Citigroup offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. You may cover your domestic partner and his or her eligible children under the following Plans:

- Medical,
- Dental;
- Vision care;
- Optional GUL/Supplemental AD&D insurance for domestic partners and life insurance for children;
- Long-Term Care insurance, available to your domestic partner even if you don't enroll in the Plan.

You may enroll your domestic partner and his or her eligible children in the medical and/or dental Plan in which you enroll. You may enroll your domestic partner in spouse Optional GUL/AD&D insurance, Long-Term Care insurance, and/or the Vision Care Plan even if you don't enroll in those Plans.

Note: None of the Citigroup medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling your domestic partner in the Plan or from your domestic partner receiving benefits for a specific condition or illness.

When you can enroll your domestic partner in Citigroup coverage

You can enroll your domestic partner and his or her eligible children for Citigroup benefits during annual enrollment (for coverage effective January 1 of the following year) or within 31 days of a qualified change in status. Examples of qualifying events that will allow you to enroll your domestic partner and his or her eligible children are:

- Upon completing a Certification of Domestic Partnership form, available through the Benefits Service Center and submitting the required supporting documentation;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

Eligibility

You're eligible to enroll your domestic partner in Citigroup coverage if you're a Puerto Rico employee who's active or on an approved leave of absence. However, if you aren't actively at work, you can't enroll your domestic partner in Long-Term Care insurance.

To be eligible for coverage, you and your partner may be of the same or opposite sex, and both of you must meet the following criteria:

- You currently share a principal residence and intend to do so permanently;
- You've lived together for at least six consecutive months prior to enrollment;
- You're financially interdependent, or your partner is dependent on you for financial support;
- Neither you nor your domestic partner is legally married to another person;
- Both of you are at least 21 years old and mentally competent to consent to contract;
- You aren't related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;

- Neither you nor your domestic partner is in a domestic partnership with anyone else;
- You've mutually agreed to be responsible for each other's common welfare; and
- You're in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

You must provide the Benefits Service Center with any documents necessary to verify your domestic partnership. Your domestic partner won't be eligible for Citigroup coverage until the documentation is received and approved. As evidence of domestic partnership, you must provide two or more of the following:

- A joint mortgage or lease;
- Designation of the domestic partner as beneficiary for life insurance or retirement benefits;
- Joint wills or designation of the domestic partner as executor and/or primary beneficiary;
- Designation of the domestic partner as durable power of attorney or health care proxy;
- Ownership of a joint bank account, joint credit cards, or other evidence of joint financial responsibility;
- Joint title to property or business assets;
- Cosigned lease or loan;
- Evidence of shared residence: utility bill, bank statement, driver's license; or
- Other evidence of economic interdependence.

The children of your domestic partner are eligible for coverage if they:

- Are the biological or adopted children of your domestic partner, children for whom your domestic partner has legal guardianship, or children who've been placed in your home for adoption; and
- Are living with you and your domestic partner on a full-time basis or living away at school; and
 - Are under the age of 19¹; or
 - Are under the age of 25¹ and are full-time students at an accredited school or college; (during enrollment each year, you'll be prompted to certify that your domestic partner's eligible child is a student even though you may not be changing medical Plans; you also must provide proof of student status in writing upon request); or
 - Were covered under the Plans before age 19, or age 25 as full-time students, and they become incapable of self-sustaining employment due to a disability, in which case they may be eligible for coverage beyond such age.

¹ Coverage will remain in effect through December 31 of the year in which the child becomes ineligible or turns 25.

Refer to the Long-Term Care section for specific dependent eligibility under that Plan.

Your taxes may be affected when you enroll your domestic partner in Citigroup coverage. For information on how tax laws may apply to your personal situation, consult your tax adviser.

However, generally, if you enroll your domestic partner or your partner's children in Citigroup coverage, the value of their coverage is considered income to you.

This additional income, known as “imputed income,” will be shown on your pay statement for the year in which coverage was effective. You’ll be required to pay taxes on this additional income.

Maternity benefits

Group health plans and health insurance issuers (including HMOs) 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 doesn’t prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging 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/96 hours.

Women’s Health and Cancer Rights Act notice

The Women’s Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans and HMO options provide the coverage described in the previous sentence.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you’ll also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymph edemas.

Qualified Medical Child Support Orders (QMCSOs)

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Medical Plan or Citigroup Dental Plan who’s an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the medical and dental Plans.

In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in the case of a divorce or separation.

Call the Plan Administrator to receive, at no cost, a detailed description of the procedures for a QMCSO. However, if you have a question about filing a QMCSO, call the Benefits Service Center as instructed on page 7. You can file your QMCSO by mailing it to:

Citigroup QMCSO Administration
P.O. Box 56757
Jacksonville, FL 32241-6757.

Medical

Citigroup offers coverage in Puerto Rico through Triple-S, a preferred provider organization (PPO). This plan doesn't have a pre-existing condition limitation or exclusion.

Triple-S PPO

In brief, the PPO allows you a choice each time you need medical care. You can choose a network provider and make a copayment for each visit, or you can choose an out-of-network provider and meet an annual deductible before the plan will pay any benefits. You'll pay more out of your pocket when using an out-of-network provider.

The Triple-S PPO gives you the freedom to choose any doctor or hospital — without a referral — when you need medical treatment. The choice is always yours.

When you visit a doctor who participates in the PPO network, you'll pay a \$10 copayment for each generalist physician, specialist, or sub-specialist office visit.

PPO network features

- Triple-S has a network of providers throughout Puerto Rico.
- Triple-S is a member of the Blue Cross and Blue Shield Association. Access to providers in the United States and around the world is available through the Blue Card Program and Blue Card Worldwide.
- You may visit a specialist at any time without a referral.
- For a network hospital admission or hospitalization, the plan will pay 100% of covered charges after a copayment of \$150 (\$50 for partial hospitalizations).
- Most outpatient services are covered after paying 10% coinsurance.
- You don't need to file a claim for covered services delivered by a network provider.

Preventive care

Preventive care services are available in the Triple S PPO Plan.

Annual allowance: Each participant has an annual allowance toward routine periodic exams performed in the Santurce Medical Mall in San Juan or in the Servicio de Salud Industrial de Ponce.

Routine physical exams, routine ob-gyn exams, and other preventive services are covered at 100% up to \$300 (Santurce) or \$295 (Ponce) annually.

Services available at these centers include the following:

- Clinical history;
- Physical exam;
- Vision exam;
- Audiometry;
- Spirometry;
- Chest x-ray;

- Comprehensive metabolic panel;
- Complete blood count;
- Liver profile;
- Lipid profile;
- Urinalysis;
- Thyroid stimulating hormone;
- Occult blood in stools test;
- Prostate Specific Antigen;
- Electrocardiogram (EKG);
- Coronary risk profile;
- Tension Management Inventory; and
- Final interview.

The preventive allowance provides a one-time visit only during the contract year that will include all the services provided by that specific center. During that visit, the participant will receive all the services included in the package. There are no subsequent visits.

Cancer screens and well-child immunizations: Both cancer screening tests and well-child immunizations performed by network providers are covered at 100% after your copayment.

Preventive care services include:

- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis
- Well-child-care services such as routine preventive pediatric care; and
- Routine well-woman exams such as routine ob-gyn visits.

Cancer screening tests are:

- PAP smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy; and
- PSA test.

Infertility

The Triple S PPO Plan covers the medical and pharmacy expenses associated with infertility treatment. The medical infertility treatment includes in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments.

The infertility benefit covers:

- Prescription drug expenses (managed by Caremark PCS) associated with infertility treatment up to a \$7,500 family lifetime maximum for participants. This maximum is combined with any infertility benefits used in the U.S. Prescription Drug Plan and
- Medical expenses up to a \$24,000 family lifetime maximum. This maximum is combined with any infertility benefits used in any of the U.S. non-HMO plans.

For the donor, the Plan covers the cost of 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; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs.

The lifetime maximum per person can be spent in one year or over a number of years. If you become a U.S. employee, the non-HMO Plan administrators and Triple S will keep track of the amount you have remaining toward this benefit.

Call your Plan if you have questions about specific procedures or treatments.

PPO out-of-network features

- You must meet an annual \$50 individual deductible (\$150 family) before the plan will pay any benefits.
- Most covered expenses are reimbursed at 80% of reasonable and customary charges after the annual deductible is met.
- You must notify Triple-S before undergoing certain procedures and receiving certain services.
- You must file a claim to be reimbursed for covered expenses delivered by out-of-network providers.
- The plan has a \$1 million lifetime maximum benefit for out-of-network benefits.
- The annual out-of-pocket expense maximum will be \$3,000 for an individual and \$6,000 for a family.

Additional medical plan information

Prescription drugs

When you enroll in the Triple-S PPO, you have prescription drug coverage in the Citigroup Prescription Drug Program, administered by CaremarkPCS, doing business as AdvancePCS. CaremarkPCS is the new parent company for AdvancePCS. Please continue to use your current AdvancePCS prescription card for your prescription drugs. New cards *won't* be issued at this time.

Caremark offers two ways to purchase prescription drugs:

- A network of retail pharmacies where you can obtain prescription drugs for your immediate short-term needs, for example, an antibiotic to treat an infection.
- The Caremark Mail Service Pharmacy, through which you may save money by having your maintenance drugs delivered by mail. Through the Caremark Mail Service Pharmacy, you can buy up to a 90-day supply of your medication. You make one copayment for each prescription or refill for less than what you'd pay to purchase the same amount at a retail network pharmacy.

Retail network pharmacies

Caremark has a network of retail pharmacies throughout Puerto Rico and the United States where you can obtain prescription drugs.

To find out whether a pharmacy participates in the Caremark network:

- Ask your pharmacist or
- Visit <http://www.caremark.com> and use the online pharmacy locator.

To have your prescription filled at a network pharmacy, present your prescription drug ID card. You'll be charged the appropriate copayment based on whether your pharmacy participates in the primary network and whether your prescription is for a generic drug or a brand-name drug.

Copayments are shown below. There's a limit of 15 days for acute drugs and 30 days for maintenance drugs. You'll never pay more than the cost of the drug.

Caremark Mail Service Program

For prescription drugs you take over an extended period of time, such as blood pressure medication, insulin, or contraceptives, you may want to use the Caremark Mail Service to save on the cost of the drug.

Through the Caremark Service Pharmacy, you can buy up to a 90-day supply of medication. You make one copayment for each prescription or refill for the same amount or less than what you'd pay to purchase the same amount at a retail network pharmacy with the convenience of having the medication delivered to your home.

With the Caremark Mail Service Pharmacy:

- Your medications are dispensed by one of the Caremark home delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no additional cost to you. Overnight or second-day shipping is available for an added charge.
- You can order and track your prescriptions online at www.caremark.com, or you can call Caremark and order your refill by telephone.
- Registered pharmacists are available 24 hours a day for consultations.

How to use the Caremark Mail Service Pharmacy

1. Ask your doctor to write two prescriptions:
 - One for a short-term supply (e.g., 30 days) to be filled immediately at a participating drug store.
 - One for the maximum days' supply allowed by your plan (e.g., up to 90 days) with as many as three refills (if appropriate) to mail to Caremark Mail Service.
2. Complete the Caremark Mail Service order form available online or in your HR department. An incomplete form can cause delay in processing.
3. Mail your order form, along with your prescription and payment, in the Caremark Mail Service envelope. Caremark Mail Service accepts VISA, MasterCard, Discover, or American Express. You can also pay by check or money order. Don't send cash.
4. Allow 10-14 days (from the day you mail your order) for the delivery of your medication.

Refills: The information included with your order will show the date that you can request a refill and the number of refills remaining. You may order your refills online at www.caremark.com or by calling the toll-free number on your prescription label.

CITIGROUP PRESCRIPTION DRUG PROGRAM		
	Retail	Mail Service (90-day supply)
Copayment/coinsurance for up to a 15-day supply (acute drugs) or 30-day supply (maintenance drugs) at a retail primary network pharmacy <ul style="list-style-type: none"> • Generic drug¹ • Brand name drug 	\$2 copayment 20% coinsurance with a \$4 minimum	\$6 copayment \$12 copayment
Benefits at a pharmacy outside the primary network <ul style="list-style-type: none"> • Generic drug¹ • Brand name drug 	10% coinsurance with a \$5 minimum 20% coinsurance with a \$10 minimum	N/A

¹ The use of generic equivalents whenever possible is more cost-effective. If the physician allows a brand to be substituted for a generic, and you choose to take the brand-name drug, you must pay the difference in price between the generic drug and brand-name drug. For example, if the generic product has a maximum allowable cost of \$10, and you choose a brand-name product that costs \$50, you'll be charged the differential cost of \$40, plus your generic copayment.

Managed drug limitations

Some medications, such as migraine agents and proton pump inhibitors, will be limited under clinical guidelines to a certain quantity within a given time frame.

Acute drugs are covered up to a 15-day supply at a network retail pharmacy.

The guidelines for use and quantity were developed by doctors and pharmacists based on accepted medical practices, Food and Drug Administration (FDA) guidelines, the recommendations of the drug manufacturer, and the cost-effective use of medicines.

In some cases, the quantity of your medication may require approval before it can be dispensed, if this is the case, your pharmacist can call Caremark at a special toll-free number that will be identified to the pharmacy at the time it processes the claim. Or you can ask your doctor to call Caremark directly.

If you or your pharmacy calls Caremark, it will need to contact your doctor, which typically takes one to two business days. Once your doctor provides the required information, Caremark will review your case based on clinical criteria and the information from your doctor. Once the review is completed, Caremark will advise your doctor and pharmacist of the decision.

If your medication or the requested quantity isn't approved for coverage under the Citigroup Prescription Drug Program, you'll be responsible for paying the full cost of the drug.

Mental health and substance abuse benefits

Triple-S PPO provides confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

Precertification

Precertification helps ensure that you obtain the most appropriate care for your condition.

You aren't required to obtain precertification for emergency hospitalization or other emergency services occurring outside Puerto Rico or the United States.

If you're using services outside the Triple-S PPO network in Puerto Rico, you'll be reimbursed based on the contracted fees established with Triple-S participating providers.

For outpatient services and diagnostic testing

You should notify the health plan at least five business days before receiving any of the following services:

- Certain surgeries, such as upper eyelid surgery breast reconstruction (other than following surgery for cancer), breast reduction and any other surgery that could be related to cosmetic surgery. In the case of eyelid surgeries and surgeries related to cosmetic surgeries, a second opinion is required;
- Out-of-network care;
- Specialist-to-specialist referrals; and
- Rehabilitation care.

Dental

Citigroup offers two dental plans:

- Basic dental and
- Comprehensive dental.

Both dental plans are administered by Triple-S. You can enroll in dental coverage even if you don't enroll in medical coverage. You can enroll in coverage for yourself or for yourself and your eligible dependents in the same four coverage categories available for medical coverage. See "Coverage categories" on page 13.

DENTAL PLAN FEATURES		
	Basic Dental	Comprehensive Dental
Preventive and diagnostic services	100% paid	100% paid
Basic services	100% paid	100% paid
Endodontic services	100% paid	100% paid
Amalgam, silicate acrylic, synthetic porcelain filling restorations to diseased or fractured teeth	100% paid; 30% coinsurance for composite filling restoration	100% paid; 30% coinsurance for composite filling restoration
Space retainers	Not covered	50% coinsurance
Prosthodontic services, subject to pre-certification	Not covered	50% coinsurance; maximum benefit \$800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Periodontal services	Not covered	\$50 copayment and 50% coinsurance; maximum benefit \$800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Orthodontia	Not covered	\$50 copayment and 50% coinsurance \$3000 lifetime orthodontia limit
Implants	Not covered	50% no maximum

Basic Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filling restoration is covered at 70% of contracted fees.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

Comprehensive Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filling restoration is covered at 70% of contracted fees.
- Space retainers are covered at 50% of contracted fees.
- Prosthodontic services are covered at 50% of contracted fees, subject to precertification.
- Periodontal services are covered at 50% of contracted fees after a \$50 copayment.

- Orthodontia is covered for participants up to age 19 only at 50% after a \$50 copayment and a \$3,000 lifetime maximum per covered person.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

Vision Care Plan

The Vision Care Plan, administered by Davis Vision, offers a variety of vision care services and supplies. You don't have to be enrolled in the plan to cover a dependent.

The two-year lock-in that required you to participate in the plan for two consecutive years has been eliminated beginning in 2006. Instead of one benefit every 24 months, you're eligible for an eye examination and one pair of eyeglasses (frame and lenses) or contact lenses, in lieu of eyeglasses, each calendar year even if you took advantage of this benefit in 2005. Additional features include services for low vision and a \$225 benefit for medically necessary contact lenses purchased at an out-of-network provider with prior approval from Davis Vision.

Both network and out-of-network benefits are available. You can split your benefit by going to both network and out-of-network providers. For example, you can obtain an annual eye examination from a Davis Vision provider while purchasing your frames and lenses out of network. Please verify that outside prescriptions are honored at any location where you wish to obtain eyewear only.

Vision Care Plan features

You'll receive a different level of benefits depending on whether you use network or out-of-network providers.

Network benefits

- Examination: One eye examination, including dilation when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each year from the Davis Vision "Tower Collection" covered at 100%; or
- A \$50 wholesale allowance toward the cost of any non-Tower frame or an equivalent retail allowance at a retail chain, for example, a \$100 allowance at a Pearle Vision location. Spectacle lenses will be covered at 100% with any non-Tower frame; or
- Contact lenses in lieu of eyeglasses: one pair or supply each calendar year in lieu of eyeglasses covered at 100%; lenses can be
 - Soft, standard daily-wear contact lenses; or
 - Plan-covered disposable/planned replacement lenses; if you choose contact lenses that are not covered under the Plan formulary, you'll receive a maximum credit of \$105 toward other lenses (a \$105 credit is allowed toward non-plan contacts, fitting, and follow-up);
- 20% discount on additional pairs of glasses at a network provider;

The following lenses are covered at 100%: glass or plastic lenses (single, bifocal, or trifocal); all prescription ranges, including post-cataract lenses; tinting of plastic lenses; standard and premium progressive addition multifocals; polycarbonate lenses; oversize lenses; ultraviolet coating; blended segment lenses; PGX (sun-sensitive) glass lenses; scratch-resistant coating; and intermediate-vision lenses.

Optional lens features, such as anti-reflective coatings; hi-index lenses; polarized lenses; and plastic photosensitive lenses, are available for a copayment.

Out-of-network benefits

If you receive services outside the Davis Vision provider network, the Plan will reimburse you up to:

- Annual exam, \$30;
- Lenses: single vision, \$25; bifocal, \$35; trifocal, \$45; lenticular, \$60;
- Frame only: \$50
- Contact lenses: \$75 elective; \$225 medically necessary (with approval from Davis Vision);

Definition of medical necessity

Davis Vision may determine your contact lenses to be medically necessary and appropriate in the treatment of certain conditions. In general, contact lenses may be medically necessary and appropriate when their use, in lieu of eyeglasses, will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Contact lenses may be determined to be medically necessary in the treatment of keratoconus, anisometropia corneal disorders, pathological myopia, aniseikonia post-traumatic disorders, Aphakia, aniridia, and irregular astigmatism. Coverage for medically necessary contact lenses will be provided after review and approval of Davis Vision.

Low vision

Low vision is defined as a significant loss of vision but not total blindness. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices and provide training and instruction to maximize the usable vision that remains.

With prior approval by Davis Vision, covered low-vision services will include:

- Low-vision evaluation: One comprehensive exam every five years with a maximum charge of \$300; sometimes called a functional vision assessment, this exam can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast, and lighting requirements for optimum vision.
- Maximum low-vision aid: Aids such as high-power spectacles, magnifiers, and telescopes, are covered at a maximum of \$600 per aid with a lifetime maximum of \$1,200. These devices are used to improve the levels of sight, reduce problems of glare, or increase contrast perception based on the individual's visual goals.
- Follow-up care: four visits in any five-year period with a maximum charge of \$100 per visit.

Lasik

Davis Vision offers you the opportunity to receive \$100 off each eye for laser vision correction, known as Lasik at any laser facility of your choice in Puerto Rico. You must submit a claim form to be reimbursed. For more information about Lasik, call Davis Vision at 1-877-923-2847 or visit www.davisvision.com.

Health care ID cards

If you enroll in the Triple-S medical plan or a dental plan for the first time, you'll receive your ID cards within three weeks of enrolling. You'll receive two separate ID cards: a medical/ dental card from Triple-S and a prescription drug card from AdvancePCS.

Note: All ID cards will be mailed to the employee. If you have a student dependent living away from home, you must send that dependent his or her cards. Cards are required to obtain services.

If you're enrolled in 2006 medical coverage and need to use a medical provider (doctor or hospital) in 2006 *before* you receive your ID card, show your confirmation statement or default statement along with the Triple-S group number (1-03450) to your provider. Call Triple-S at 1-787-749-4777 to request coverage certification or a duplicate ID card.

Disability

Short-Term Disability (STD) and Long-Term Disability (LTD) benefits are available to replace a portion or all of your earnings if you're unable to work due to an illness, injury, or pregnancy.

Short-Term Disability (STD)

The STD Plan (salary continuation) is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Plan administrator before you can receive a benefit.

STD pays 100% or 60% of base salary (not total compensation) during an approved disability of up to 13 weeks based on your length of service.

STD schedule of benefits			
Years of service	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of base salary
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

For financial consultants, account executives, financial consultant associates, and investment associates in the Global Corporate and Investment Bank the following schedule of benefits applies:

Years of service	Minimum benefit (% of total compensation)	Plus additional Benefit	Maximum benefit (% of total compensation)
1 month to less than 3 years	60%	Commissions	100%
3 years to less than 7 years	70%	Commissions	100%
7 or more years	80%	Commissions	100%

For employees paid on commission working in the Global Consumer Group: You'll receive STD benefits based on a phantom salary (and not based on total compensation). If any commissions are generated while you're on an STD leave, they'll be paid in addition to the STD benefit based on your length of service.

If you're a Smith Barney business analyst paid a monthly commission: You'll receive STD benefits based on a recoverable draw against commissions.

For other employees paid on commission: Ask your HR representative for details.

When STD benefits are payable

STD benefits are payable if you incur a total disability while actively employed. A "total disability" is defined as a serious health condition, pregnancy, or injury that results in your inability to perform the essential duties of your regular occupation for more than seven consecutive calendar days. If you remain totally disabled and are unable to work on the eighth calendar day, STD benefits — if approved — will begin on the eighth day of disability and will be paid retroactive to the first day of disability.

You aren't considered to have a disability if your illness, injury, or pregnancy only prevents you from commuting to and from work. To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You can't qualify for STD benefits if you return to work on a part-time basis.

If you qualify for STD benefits, return to work, and then within a 30-day period or less you're unable to return to work for the same or a related total disability, your absence will be processed as a recurrent claim and you'll be eligible to receive the *balance* of your STD benefits (for a reduced period to reflect the STD benefits paid prior to your absence).

Long-Term Disability (LTD)

LTD coverage is offered to continue 60% of your total compensation when an approved disability continues for more than 13 weeks.

Citigroup provides free LTD coverage to employees whose total compensation is less than or equal to \$50,000.99, while employees with total compensation of \$50,001 and above can buy coverage. The cost of LTD coverage is shown on the Citigroup Benefits Web Site or on your Personal Enrollment Worksheet.

If you've been enrolled in the Plan for one year and leave Citigroup, you can convert your Citigroup LTD coverage under the group policy to an individual policy. The maximum benefit of this individual policy is \$3,000 per month.

You may be eligible to receive LTD benefits after 13 weeks of an approved STD. Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins).

Unless you're financially independent, you should think of LTD protection as an essential element of your personal financial plan since LTD coverage protects you in the event your ability to work is impaired by an accident or sickness.

You don't have to enroll in Citigroup LTD coverage. However, if you decide to enroll in LTD coverage at any time other than when first eligible or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health. In addition, the Plan won't cover any disability caused by, contributed to by, or resulting from a pre-existing condition until you've been enrolled in the Plan for 12 consecutive months.

A pre-existing condition is an injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

IF YOUR TOTAL COMPENSATION IS:	
\$50,000.99¹ or less	<ul style="list-style-type: none">• Citigroup provides LTD coverage at no cost to you• Your benefit is taxable
From \$50,001 to \$500,000²	<ul style="list-style-type: none">• You'll pay for coverage with after-tax dollars• Your benefit isn't taxable

¹ If your total compensation increases above \$50,000.99 during the year and you want LTD coverage for the following year, you must enroll during annual enrollment. Otherwise, you won't have any LTD coverage beginning the first of the following year.

² If you don't enroll in coverage up to your total compensation and decide to increase coverage at a later date, you'll be required to provide evidence of good health before the additional coverage will be approved.

AGE DISCRIMINATION IN EMPLOYMENT ACT (ADEA) SCHEDULE	
Age when total disability begins	Date monthly LTD benefits will stop
Age 62 or under	The later of: <ul style="list-style-type: none"> Your 65th birthday or The date the 42nd monthly benefit is payable
Age 63	The date the 36 th monthly benefit is payable
Age 64	The date the 30 th monthly benefit is payable
Age 65	The date the 24 th monthly benefit is payable
Age 66	The date the 21 st monthly benefit is payable
Age 67	The date the 18 th monthly benefit is payable
Age 68	The date the 15 th monthly benefit is payable
Age 69 or over	The date the 12 th monthly benefit is payable

When LTD benefits are payable

For purposes of qualifying for LTD benefits, a disability means that due to sickness, pregnancy, or accidental injury, you're receiving appropriate care and treatment from a doctor on a continuing basis and are unable to perform your own occupation for any employer in your local economy.

LTD benefits become payable after you're approved for and receive 13 weeks of STD benefits. To qualify for LTD benefits, you must be under the continuous care of a doctor during the STD period.

If you qualify for STD benefits, return to work, and then, within a 30-day period or less, you're unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim and you may begin LTD benefits when you're approved for and receive the balance of your STD benefits.

The receipt of STD and LTD benefits is subject to the terms and conditions of the applicable Plan. This section isn't intended to be a substitute for the actual Plan documents.

To review the STD and LTD Plan documents, visit www.benefitsbookonline.com.

Life insurance benefits

Basic Life/AD&D insurance

Citigroup provides Basic Life insurance (through MetLife) and Accidental Death and Dismemberment (AD&D) insurance (through CIGNA) at no cost to you. AD&D pays a benefit if you're dismembered or die as a result of an accidental injury.

The benefit is equal to your total compensation up to a maximum of \$200,000, rounded up to the nearest \$1,000. This amount won't change during the year if your total compensation changes. Total compensation is recalculated each year, and the new amount is effective each January 1.

Since Citigroup pays the full cost of your Basic Life insurance, you must pay taxes on the value of the coverage above \$50,000. As required by the IRS, this amount, called “imputed income,” will be added to your taxable pay and shown on your pay statement and Form W-2 for the year in which coverage was effective. Imputed income is based on the amount of Basic Life insurance coverage above \$50,000 and your age.

If your total compensation is more than \$50,000, you may elect only \$50,000 in Basic Life insurance. You won’t be subject to the imputed income, but you’ll also forego the additional benefit. You won’t have the opportunity to enroll in Basic Life equal to your total compensation until the next annual enrollment period.

Basic Life accelerated benefits option

The accelerated benefits option (ABO) of your life insurance coverage is available if you become terminally ill due to injury or sickness and are expected to die within six months.

Under the ABO, you may receive up to 50% of your Basic Life amount not to exceed \$100,000, less any applicable expense charges. The minimum amount that will be paid is the lesser of 25% of your Basic Life amount or \$7,500. The accelerated benefit will be paid in a lump sum unless you or your legal representative selects another payment mode.

To receive an accelerated benefit, MetLife will require the following proof of your terminal illness:

- A completed accelerated benefit claim form, available from MetLife;
- A signed physician’s certification that states you’re terminally ill; and
- An examination by a physician of MetLife’s choice, if requested, at no expense to you.

Accelerated benefits will be paid only once in your lifetime. Upon your death, the Basic Life benefit paid to your beneficiary will be decreased by the amount of the accelerated benefit paid plus any interest and expense charge.

Optional GUL/Supplemental AD&D insurance

The Optional GUL and Supplemental AD&D coverage described below isn’t an employee benefit arrangement sponsored by Citigroup. The insurance coverage is offered solely as a convenience to employees of Citigroup and isn’t endorsed by the Company.

Coverage for employees

You can enroll in Optional GUL insurance for yourself from one to 10 times your total compensation up to a maximum coverage amount of \$5 million. If your total compensation isn’t an even multiple of \$1,000, your coverage amount will be rounded up to the next \$1,000.

You must provide evidence of good health to enroll in this coverage or, if already enrolled, to increase your coverage.

Your cost is based on the amount of coverage you elect, your age, and whether you’ve used tobacco products in the past 12 months.

If your total compensation is reduced, your Optional GUL amount will continue to be based on the higher total compensation unless you call the Benefits Service Center to request that the Optional GUL amount be reduced. Once you reduce coverage, you can increase it only by purchasing additional multiples of your total compensation. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective.

If you leave Citigroup you can continue coverage. MetLife will bill you directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment.

Once enrolled for Optional GUL (provided by MetLife), you automatically receive Supplemental AD&D coverage in the same amount as your GUL coverage. AD&D coverage is provided by CIGNA.

Optional GUL accelerated benefits option

The accelerated benefits option (ABO) of your GUL coverage is available if you become terminally ill due to injury or sickness and are expected to die within six months.

Under the ABO, you may receive up to 50% of your GUL insurance amount, not to exceed \$250,000, less any applicable expense charges. The accelerated benefit will be paid in one lump sum unless you or your legal representative selects another payment mode.

To receive an accelerated benefit, MetLife will require the following proof of your terminal illness:

- A completed accelerated benefit claim form available from MetLife;
- A signed physician's certification that states you're terminally ill; and
- An examination by a physician of MetLife's choice, if requested, at no expense to you.

Accelerated benefits will be paid only once in your lifetime. Upon your death, the GUL benefit paid to your beneficiary will be decreased by the amount of the accelerated benefit paid plus any interest and expense charge.

Accelerated benefits are not payable if:

- You've assigned the death benefit;
- All or a portion of your death benefit is to be paid to your former spouse as part of a divorce agreement;
- You attempt suicide or injure yourself on purpose;
- The amount of your death benefit is less than \$15,000; or
- You're required by a government agency to request payment of the accelerated benefit so you can apply for, obtain, or keep a government benefit or entitlement.

Cash Accumulation Fund (CAF)

When you enroll in Optional GUL/Supplemental AD&D coverage, you can participate in the CAF. The CAF allows you to save money that earns a competitive rate of interest on a tax-deferred basis. Contributions are deducted from your pay each pay period. The minimum contribution is \$10 a month or \$120 a year.

The IRS determines the annual maximum you can contribute based on your Optional GUL coverage amount, your age, and other factors. You'll see your minimum and maximum contributions on the Citigroup Benefits Web Site or on your Personal Enrollment Worksheet. You can change the amount of your contribution at any time. **Note:** A decrease in coverage amounts could affect your CAF contributions. For details, call MetLife at 1-800-523-2894.

You won't pay taxes on the interest while it remains in the CAF. The interest is taxable only when you withdraw more than the total you have paid up to that point for Optional GUL coverage (your premiums) plus your CAF contributions. For information about your CAF, call MetLife at 1-800-523-2894.

Coverage for your spouse/domestic partner

You can enroll in Optional GUL insurance coverage for your spouse/domestic partner in increments of \$10,000 to a maximum of \$100,000. You don't need to buy Optional GUL/Supplemental AD&D for yourself to elect coverage for your spouse/domestic partner.

Within 31 days of your initial eligibility, you can enroll for up to a maximum of \$30,000 of spouse/domestic partner coverage without your spouse/domestic partner providing evidence of good health.

If you enroll at any other time, your spouse/domestic partner must provide evidence of good health for *any* amount of spouse/domestic partner coverage.

The cost of coverage is based on the amount of coverage you elect, your spouse's/domestic partner's age, and whether he/she has used tobacco products in the past 12 months.

If you leave Citigroup, you can continue coverage for your spouse/domestic partner. MetLife will bill you directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment.

You also can open a Cash Accumulation Fund in your spouse's/domestic partner's name.

Once enrolled in Optional GUL (provided by MetLife), your spouse/domestic partner automatically will receive Supplemental AD&D coverage in the same amount as his/her GUL coverage. AD&D is provided by CIGNA.

Coverage for your children

If you've enrolled in Optional GUL/Supplemental AD&D coverage for yourself or your spouse/domestic partner, you can enroll for life/AD&D insurance from \$5,000 to \$20,000, in \$5,000 increments, for your eligible dependent children. *A child must be at least 15 days old to be covered.*

When you enroll in life/AD&D coverage for your child, all of your eligible children are covered automatically.

Once enrolled for child life (provided by MetLife), your child automatically receives Supplemental AD&D coverage in the same amount as the child life coverage. AD&D is provided by CIGNA.

Note: If you're enrolled in child coverage and have or adopt another child, you must report your child's birth or adoption to the Benefits Service Center so the new child can be covered.

Business Travel Accident insurance

Business Travel Accident (BTA) provides accident insurance only and pays benefits for bodily injury and/or death; it *doesn't* provide coverage for sickness. Coverage is provided by CIGNA.

All regular full-time and part-time employees have BTA coverage of five times total compensation to a maximum benefit of \$2 million. Your spouse/domestic partner, and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

- An eligible spouse/domestic partner has a coverage amount of \$150,000.
- Each eligible dependent child has a coverage amount of \$25,000.

BTA benefits are paid in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. Certain covered losses are subject to limitations.

Your BTA beneficiary is the person or persons designated to receive any benefit payable at your death is the same beneficiary for Basic Life insurance.

Long-Term Care (LTC) insurance

You can purchase LTC coverage for yourself and eligible members of your family at any time.

To be eligible, you and your family members must reside in the United States (50 states, District of Columbia, and Puerto Rico). Eligible family members may apply even if you don't. Eligible family members are:

- Your spouse or domestic partner;
- Your parents or your parents-in-law;
- Your adult children or the adult children of your spouse or domestic partner*; and
- Spouses of your adult children.

Family members must be 18 or older.

If you're a new hire and enroll during your initial benefits enrollment: You won't have to provide evidence of good health.

If you enroll at any other time: You must provide evidence of good health acceptable to John Hancock.

In either case, coverage will be effective the first of the month after your application is approved, as long as you're actively at work on that date. If you aren't at work on the date your coverage would otherwise have become effective, your coverage will become effective the first of the month following your return to work as an active employee.

Premiums for yourself and spouse/domestic partner will be deducted from your pay. You'll pay for coverage with after-tax dollars; the cost is based on your age when you become insured.

Your family members can complete an application form and must provide evidence of good health acceptable to John Hancock before coverage will be approved. Coverage will be effective the first of the month after their application is approved, provided they aren't disabled on that date.

Family members, other than spouses/domestic partners, will be billed directly. If they're disabled on that date, coverage will take effect the first of the month after their disability ends, provided they're still eligible.

For information on the cost of LTC coverage for yourself or other eligible family members, you can request an enrollment kit or obtain a personal rate quote by visiting the John Hancock Web site at <http://groupltc.jhancock.com>. The user name is "groupltc," and the password is "mybenefit." You also can call John Hancock at 1-800-222-6814.

Family members who visit the Web site or call to obtain information should provide your name as the Citigroup employee.

Enrolling in LTC coverage

Enrolling in LTC coverage will be different from enrolling in other Citigroup health and welfare benefits. You'll enroll in LTC coverage directly with John Hancock by submitting an enrollment form to John Hancock or clicking on a link from the Citigroup Benefits Web Site. Eligible family members must complete an enrollment form.

When LTC benefits are payable

In general, LTC benefits become payable if a licensed health care practitioner certifies that:

- You require substantial assistance from another person to perform at least two "activities of daily living" due to a loss of functional capacity that is expected to continue for at least 90 days or
- You need substantial supervision due to a "cognitive impairment."

Activities of daily living generally include bathing, maintaining continence, dressing, toileting, eating, and transferring into or out of a bed or chair. Cognitive impairment is a deterioration or loss of intellectual capacity comparable to Alzheimer's disease and similar forms of irreversible dementia.

You become eligible for benefits only upon confirmation of your qualifying condition by a care coordinator from John Hancock.

With limited exceptions, LTC benefits generally won't be payable until the end of a 90-day "qualification period" that begins from the date John Hancock certifies that you meet the benefit eligibility requirements. The qualification period needs to be met only once as long as you remain continuously insured.

Your qualifying condition must continue through this period, but you don't have to actually incur expenses, receive long-term care services, or be hospitalized during this period. LTC benefits are payable for covered charges you incur after the qualification period is met as long as you remain eligible for benefits.

Benefits and services covered

LTC benefits will cover actual charges incurred for qualifying services, which generally include nursing home care, alternate care facility, community-based professional care, informal care, and stay-at-home benefits. Depending on the type of service, benefits are subject to a maximum, which will vary based on the coverage level you choose.

Choosing a level of coverage

From the six options in the table below, you must choose a daily maximum benefit (DMB) from \$100 to \$350 a day in \$50 increments. The DMB is the most the Plan may pay for all covered services received on any day. Each DMB has a corresponding lifetime maximum benefit (LMB), which is the total amount payable for covered LTC services while you're insured. Informal care also is subject to a calendar year maximum.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	\$100	\$150	\$200	\$250	\$300	\$350
Alternate care facility DMB	\$100	\$150	\$200	\$250	\$300	\$350
Community-based professional care DMB ¹	\$75	\$112.50	\$150	\$187.50	\$225	\$262.50
Informal care DMB	\$25	\$37.50	\$50	\$62.50	\$75	\$87.50
Informal care calendar year maximum ²	\$750	\$1,125	\$1,500	\$1,875	\$2,250	\$2,625
Lifetime maximum benefit (excluding stay-at-home benefit)	\$182,500	\$273,750	\$365,000	\$456,250	\$547,500	\$638,750
Stay-at-home lifetime maximum	\$3,000	\$4,500	\$6,000	\$7,500	\$9,000	\$10,500

¹ This includes adult day care and the following services provided in your home: home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

² The total benefits payable for all informal care received in any calendar year is 30 times the informal care DMB.

Stay-at-home benefit

The stay-at-home benefit can be used to pay for expenses for a care planning visit, home modifications, emergency medical response system, durable medical equipment, caregiver training, home safety check, and provider-care check.

The stay-at-home benefit amount is the most the Plan will pay for the cost of all covered services received while you're insured and won't exceed 30 times the DMB. This lifetime maximum for the stay-at-home benefit is separate and in addition to the lifetime maximum for your other LTC benefits.

It's available during the qualification period; it isn't available if coverage is in reduced paid-up status and can't be restored under the restoration-of-benefits provision. The stay-at-home benefit amount will be recalculated whenever your DMB changes as a result of inflation, benefit increases, and decreases, provided you have not exhausted this benefit.

Any benefits paid will be subtracted from the recalculated amount. Except for the care planning visit, you must be residing in your home to be eligible. The maximum amount payable for caregiver training won't exceed five times your DMB.

Choosing a non-forfeiture LTC benefit or a contingent non-forfeiture LTC benefit

For an additional cost, you also can choose to include a non-forfeiture benefit (reduced lifetime maximum paid-up benefit) in your coverage at enrollment. If you don't elect this option, the contingent non-forfeiture benefit will be included in your coverage at no additional cost.

If you have been continuously insured under the Plan for at least three years, the non-forfeiture benefit (reduced lifetime maximum paid-up benefit) will allow you to stop making premium payments for any reason and retain a reduced level of coverage

If you exercise this benefit, you'll keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of 30 times your DMB or the sum of premiums paid. If you exercise this benefit after a minimum of 10 years of continuous coverage, the reduced LMB would equal the greater of 90 times the DMB or the sum of premiums paid.

The contingent non-forfeiture benefit can be exercised only in the event of a substantial premium increase. The contingent non-forfeiture benefit allows you to stop paying premiums and keep a reduced level of coverage.

If you exercise his benefit, you'll keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of the total amount of premiums paid for your insurance since your coverage was issued or 30 times the DMB. A substantial premium increase would range from 10% at issue-age 90 or older to 200% at issue-age 29 or younger as detailed in the certificate that you'll receive if you're approved for coverage.

Choosing inflation protection: ABI or future purchase option

You also have the choice of including the automatic benefit increase (ABI) inflation protection provision at enrollment for an additional cost. If you don't elect this option, the future purchase option provision will be included in your coverage.

Under the ABI option, increases to your benefit amounts occur automatically each year. Every January 1, beginning January 1, 2006, the DMB amount will be increased at an annual rate of 5% compounded. The LMB will be increased in proportion to the increase in the nursing home DMB. If your insurance becomes effective January 1, no increase will apply on your effective date of coverage.

The benefit increase will continue to be made annually regardless of your age or whether you have met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop paying premiums and continue coverage in effect on a reduced paid-up basis under the non-forfeiture benefit.

Under the future purchase option, you'll be offered additional amounts of coverage every three years to keep up with inflation. The amount of each adjustment will reflect an increase to the DMB of at least 5% compounded annually for the applicable period.

The premium rates for the inflation increase will be based on your issue age on the effective date of the increase and will include an additional charge to account for the added risk associated with accepting these offers.

The LMB will be increased in proportion to the increase in the nursing home DMB. An inflation adjustment won't be available if you're issue-age 85 or older or if you have met the benefit eligibility requirements under the policy in the six months prior to the increase effective date or if your coverage is in reduced paid-up status.

Visit the John Hancock Web site at <http://groupltc.jhancock.com> (the user name is "groupltc," and the password is "mybenefit") for an online tool that can help you determine which inflation protection provision may suit your needs.

Additional features

Return of premium at death benefit

A return of premium at death benefit is included in your coverage. This benefit will pay to your estate a portion of the premiums you paid, less any benefits paid or payable should you die prior to age 75 while covered under the Plan. The portion of the premium is based on your age at the time of death as shown below. Premiums are not returned if you're age 75 or older or if coverage is in reduced paid-up status.

Age	Percentage of premium
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%
71	40%
72	30%
73	20%
74	10%
75 or older	0%

Waiver of premium

Once you complete the qualification period, and provided you meet the benefit eligibility requirements under the policy on that date, your premium payments will be waived. The waiver will continue as long as you remain eligible for benefits.

Portability

If you retire or leave Citigroup, you may continue coverage at group rates. You'll pay premiums directly to John Hancock.

Bed reservation benefit

The Plan will continue to pay nursing home or alternate-care facility benefits for up to 60 days per calendar year if you leave the facility on a short-term basis while receiving Plan benefits.

Alternate plan of care

An alternate plan of care can be established by mutual agreement among you, a licensed health care practitioner, and John Hancock if the John Hancock care coordinator identifies alternatives to the current plan that are both appropriate for you and cost-effective. The alternate plan of care may provide benefits for services or supplies not otherwise covered by the Plan. Any benefits paid under an alternate plan of care will reduce the LMB.

Restoration of benefits

The restoration of benefits feature allows you to restore your LMB if you provide proof that you:

- Have not met the benefit eligibility criteria during the 24-month period up to and immediately preceding the date you request to restore your LMB;
- Haven't exhausted your LMB; and
- Have been continuously insured on a premium-paying basis for at least 24 months just prior to your request.

Restoration doesn't apply if coverage is in reduced paid-up status. Your stay-at-home benefit lifetime maximum won't be restored.

Coordination of benefits and exclusions

To prevent duplication of benefits, the Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the Plan when benefits are payable under another plan.

John Hancock won't pay benefits for charges incurred by the insured in certain circumstances, such as intentional self-inflicted injury; charges that are reimbursable or would be reimbursable under Medicare except for coinsurance, copayment, or deductible provisions under Medicare; or for treatment specifically provided for detoxification or rehabilitation for alcohol or drug addiction.

These exclusions may not apply in all states and may vary depending on the state in which you live. The Certificate of Insurance you'll receive once you're approved for coverage will outline the exclusions for your state. If you move to another state, the state guidelines where the Certificate of Insurance was originally delivered to you will apply.

LTC providers must meet the qualifications specified in the Certificate of Insurance, and services and supplies must be provided in accordance with a plan of care prescribed by a licensed health care practitioner.

For more information

To obtain details of the coverage available and its cost, contact John Hancock either by:

- Calling the John Hancock Long-Term Care Insurance Department at 1-800-222-6814, or
- Visiting the John Hancock Web site at <http://groupltc.jhancock.com>. The user name is "groupltc," and the password is "mybenefit."

Your family members who call or visit the Web site should provide your name as the Citigroup employee.

Glossary

Coinsurance: The portion of a covered expense that you pay after you have satisfied the deductible. For example, if a plan pays 90% of certain covered expenses, your coinsurance for these expenses is 10%.

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

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

Health Insurance Portability and Accountability Act (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost. The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they are afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status.

Medically necessary: A service or supply is considered medically necessary if it is a generally accepted health care practice and is required to treat your condition, as determined by the Claims Administrator.

Precertification: A requirement that a participant call his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. If you don't call your health plan in advance of certain procedures, your benefits will be subject to a non-notification penalty each time your plan isn't notified. Notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting. Call your plan for more information.

Pre-existing condition: An injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — you received medical treatment, consultation, care, or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

QMCSO: Qualified Medical Child Support Order.

Wellness services: Charges for routine care examinations based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams) and immunizations.

Legal and administrative information

When coverage ends

Your coverage under the Citigroup Medical Plans, Dental Plans, and Vision Care Plan automatically will terminate on the earliest of the following dates:

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

Basic Life insurance coverage ends on the date your employment is terminated.

Optional GUL insurance coverage ends on the last day of the month in which your employment terminates.

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

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

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" on page 53.

Coverage for surviving dependents

When an active employee dies, if the surviving spouse and/or dependent children were enrolled in active coverage at the time of the employee's death, then these covered individuals will be eligible to continue health care coverage for six months.

If the employee was not eligible for retiree health care coverage at the time of death: Medical and dental coverage will continue for the covered individuals for six months at

no cost. After the six-month period, they will be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period.

If the employee was eligible for retiree health care coverage at the time of death: Covered individuals will be eligible for retiree health care coverage — instead of receiving COBRA coverage — at the end of this six-month period. The retiree health care coverage will be provided on the same terms as coverage provided to a retired employee.

Coverage if you become disabled

If you're disabled, you and your eligible dependents may continue medical, dental, and vision care coverage for up to 13 weeks, as long as you make the active employee contributions.

If you're totally disabled, coverage will continue as follows.

Medical coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue medical coverage by making the same contributions as active employees, based on your length of service as shown below. (After 52 weeks of disability, your employment will be terminated.)

LENGTH OF RECOGNIZED CITIGROUP SERVICE AT THE TIME YOUR LTD IS APPROVED	MEDICAL CONTINUATION PERIOD AFTER WEEK 52 (THE TERMINATION OF YOUR EMPLOYMENT)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you're disabled or haven't reached the maximum age limit to receive LTD benefits

Your disability administrator will medically manage your disability if you're a totally disabled employee who's been denied LTD due to a pre-existing condition, didn't enroll in LTD coverage, or who's reached the maximum benefit under the two-year limitation rule.

If the administrator determines that you're totally disabled, medical coverage will continue at the active employee rate for the lesser of a length of time based on your service (see chart above) or the length of your disability.

At the end of the medical continuation period shown above, you may continue coverage through COBRA. The above continuation period is considered part of the COBRA period.

If you participate in a non-HMO medical plan, once you become disabled for over 29 months, Medicare will become your primary coverage while benefits under the Citigroup plan become secondary."

Dental coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. You may then continue coverage under COBRA. The continuation period isn't considered part of the COBRA period.

Vision care coverage will continue for the 13-week period of STD as long as you make the active employee contributions. You may then continue coverage through COBRA.

Coverage if you take a leave of absence

If you're on an approved leave of absence, call the Benefits Service Center about your rights to continue medical, dental, and/or vision coverage.

Continuing coverage during an FMLA leave

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for serious illness; the birth or adoption of a child; or to care for a spouse, child, or parent who has a serious health condition.

If you're eligible for FMLA, you may take up to a total of 13 weeks of leave each year, except where state law mandates differently.

If you take an unpaid leave of absence that qualifies under FMLA, you may continue medical, dental, and vision coverage for yourself and your dependents as long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You'll be billed directly.

If you lose any coverage during an FMLA leave because you didn't make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions.

If you don't return to work at the end of your FMLA leave, you'll be entitled to enroll in COBRA to continue your medical, dental, and vision coverage.

If your employment is terminated while you're on an FMLA leave, you also may be eligible to continue your coverage under COBRA.

Continuing coverage during a military leave

As of the printing of Citigroup's 2006 enrollment materials, Citigroup's Paid Military Leave of Absence Policy was extended through March 10, 2006. If this policy is extended beyond that date, you'll have the right to continue your health and welfare benefits in accordance with the terms and conditions of the policy.

For the latest copy of the policy, visit Citigroup.net. From the home page, use the search function and enter "military leave." Then click on the most current policy.

If you take a military leave of absence — whether for active duty or for training — you're entitled to continue your medical, dental, and vision coverage for up to 24 months as long as you give Citigroup notice (with certain exceptions) of the leave. However, this continued coverage may not be available if your total leave, when added to any prior periods of military leave from Citigroup, exceeds five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you won't be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (both Company and employee contributions). Your other benefits will be terminated at the beginning of your military leave.

If you're on a military leave for fewer than 24 months and you don't return to work at the end of your leave, you may be entitled to purchase continuation coverage for the remaining months, up to a total of 24 months.

Call the Benefits Service Center or contact your HR representative for more information about a military leave.

Notice of HIPAA Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information.

This Notice of Privacy Practices describes how the Citigroup Medical Plan, Citigroup Dental Plan, Citigroup Vision Care Plan, and HCSA (collectively referred to in this Notice as an "Organized Health Care Arrangement" and each individually, referred to in this Notice as a "Component Plan"), may use and disclose your protected health information.

This Notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. The Component Plans have all agreed to abide by the terms of this Notice. This Notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

For answers to your questions and for additional information. If you have any questions or want additional information about this Notice, contact Citigroup as instructed on page 53. To exercise any of the rights described in this Notice, contact the third-party administrator for the relevant Component Plan as instructed on page 53.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (i) that is created or received by a health care provider, health plan, insurance company, or health care clearinghouse; (ii) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (iii) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan. Component Plans are obligated to provide you with a copy of this Notice setting forth their legal duties and privacy practices regarding your protected health information. Component Plans must abide by the terms of this Notice.

Uses and disclosures of Protected Health Information

The following describes when any Component Plan is permitted or required to use or disclose your protected health information. This list is mandated by the HIPAA Privacy Rule.

Payment and health care operations

Each Component Plan has the right to use and disclose your protected health information for all activities that are included within the definitions of “payment” and “health care operations” as defined in the HIPAA Privacy Rule.

Payment. Component Plans will use or disclose your protected health information to fulfill their responsibilities for coverage and providing benefits as established under their governing documents. For example, Component Plans may disclose your protected health information when a provider requests information regarding your eligibility for benefits under a Component Plan, or it may use your information to determine if a treatment that you received was medically necessary.

Health care operations. Component Plans will use or disclose your protected health information to fulfill Component Plans’ business functions. These functions include, but are not limited to, quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, a Component Plan may use or disclose your protected health information (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs; or (iv) to survey you concerning how effectively such Component Plan is providing services, among other issues.

Business associates. Each Component Plan may enter into contracts with service providers — called business associates — to perform various functions on its behalf. For example, Component Plans may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information but only after such Component Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Organized health care arrangement. Component Plans may share your protected health information with each other to carry out payment and health care activities.

Other covered entities. Component Plans may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with certain health care operations. For example, Component Plans may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and Component Plans may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing, or credentialing.

This also means that Component Plans may disclose or share your protected health information with other health care programs or insurance carriers (including, for example, Medicare or a private insurance carrier, etc.) to coordinate benefits, if you or your family members have other health insurance or coverage.

Required by law. Component Plans may use or disclose your protected health information to the extent required by federal, state, or local law.

Public health activities. Each Component Plan may use or disclose your protected health information for public health activities permitted or required by law. For example, each Component Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. Component Plans also may disclose protected health information, if directed by a public health authority, to a foreign government agency collaborating with the public health authority.

Health oversight activities. Component Plans may disclose your protected health information to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and other legal proceedings. Component Plans may disclose your protected health information in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized in the court order). If certain conditions are met, Component Plans may also disclose your protected health information in response to a subpoena, a discovery request, or other lawful process.

Abuse or neglect. Component Plans may disclose your protected health information to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if a Component Plan believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your protected health information to a government entity authorized to receive such information.

Law enforcement. Under certain conditions, Component Plans also may disclose your protected health information to law enforcement officials for law enforcement purposes. These law enforcement purposes include, by way of example, (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (3) as relating to the victim of a crime.

Coroners, medical examiners, and funeral directors. Component Plans may disclose protected health information to a coroner or medical examiner when necessary for identifying a deceased person or determining a cause of death. Component Plans also may disclose protected health information to funeral directors as necessary to carry out their duties.

Organ and tissue donation. Component Plans may disclose protected health information to organizations that handle organ, eye, or tissue donation and transplantation.

Research. Component Plans may disclose your protected health information to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information or (2) the research involves a limited data set that includes no unique identifiers (information such as name, address, Social Security number, etc., that can identify you).

To prevent a serious threat to health or safety. Consistent with applicable laws, Component Plans may disclose your protected health information if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Component Plans also may disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military. Under certain conditions, Component Plans may disclose your protected health information if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you're a member of foreign military service, Component Plans may disclose, in certain circumstances, your information to the foreign military authority.

National security and protective services. Component Plans may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons, or heads of state.

Inmates. If you're an inmate of a correctional institution or under the custody of a law enforcement official, Component Plans may disclose your protected health information to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation. Component Plans may disclose your protected health information to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the plan sponsor. Component Plans (or their respective health insurance issuers or HMOs) may disclose your protected health information to Citigroup and its employees and representatives in the capacity of the sponsor of the Component Plans.

Others involved in your health care. Component Plans may disclose your protected health information to a friend or family member involved in your health care, unless you object or request a restriction (in accordance with the process described under “Right to request a restriction” on page 51). Component Plans also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you aren’t present or able to agree to these disclosures of your protected health information, then, using professional judgment, Component Plans may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. Each Component Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining a Component Plan’s compliance with the HIPAA Privacy Rule.

Disclosures to you. Each Component Plan is required to disclose to you or to your personal representative most of your protected health information when you request access to this information. Component Plans will disclose your protected health information to an individual who has been designated by you as your personal representative and who is qualified for such designation in accordance with relevant law.

Prior to such a disclosure, however, each Component Plan must be given written documentation that supports and establishes the basis for the personal representation. A Component Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or such Component Plan determines, in the exercise of its professional judgment, that it isn’t in your best interest to treat the person as your personal representative.

Other uses and disclosures of your Protected Health Information

Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization as provided to each Component Plan. If you provide such authorization to a Component Plan, you may revoke the authorization in writing, and such revocation will be effective for future uses and disclosures of protected health information upon receipt. However, the revocation won’t be effective for information that such Component Plan has used or disclosed in reliance on the authorization.

Contacting you

Each Component Plan (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you.

Your rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request using the contact information on page xx.

Right to request a restriction. You have the right to request a restriction on the protected health information that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care.

You may request such a restriction using the contact information on page xx. A Component Plan isn't required to agree to any restriction that you request. If a Component Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the protected health information you wish to limit, whether you want to limit such Component Plan's use, disclosure, or both, and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse).

Right to request confidential communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information on page xx.

Your request must specify the alternative means or location for communication with you. It also must state that the disclosure of all or part of the protected health information in a manner inconsistent with your instructions would put you in danger. A Component Plan will accommodate a request for confidential communications that reasonable and states that the disclosure of all or part of your protected health information could endanger you.

Right to request access. You have the right to inspect and copy protected health information that may be used to make decisions about your benefits. You must submit your request in writing. If you request copies, the relevant Component Plan may charge you for photocopying your protected health information, and for postage, if you request that copies be mailed to you. The third-party administrators of the Component Plans have indicated that they don't currently intend to charge for this service, although they reserve the right to do so.

Note: Under federal law, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to request an amendment. You have the right to request an amendment of your protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request

must be submitted in writing using the contact information on page xx and must set forth a reason(s) in support of the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

For example, a Component Plan may deny your request if the information you want to amend is accurate and complete or was not created by such Component Plan. If a Component Plan denies your request, you have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed information, and all future disclosures of the disputed information by such Component Plan will include your statement.

Right to request an accounting. You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information on page xx. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

You're entitled to one accounting from each Component Plan free of charge during a 12-month period. There may be a charge to cover a Component Plan's costs for any additional requests within that 12-month period. Component Plans will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to a paper copy of this notice. You have the right to a paper copy of this Notice, even if you have agreed to accept this Notice electronically. To obtain such a copy, see the contact information on page xx.

Complaints

If you believe a Component Plan has violated your privacy rights, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information on page xx. Component Plans won't penalize you for filing a complaint.

Changes to this Notice

Component Plans reserve the right to change the provisions of this Notice and to make the new provisions effective for all protected health information that they maintain. If a Component Plan makes a material change to this Notice, it will provide a revised Notice to you at the address that it has on record for the participant enrolled with such Component Plan (or, if you agreed to receive revised Notices electronically, at the e-mail address you provided to such Component Plan).

Effective date

This Notice of Privacy Practices became effective April 14, 2003.

Contact information

For more information about any of the rights in this Notice, or to file a complaint, contact:

Citigroup Privacy Officer
c/o Corporate Benefits Department
125 Broad St., 8th Floor
New York, NY 10004.

To exercise any of the rights described in this Notice, contact the third-party administrators for the Component Plans as follows.

If you're enrolled in any of these plans:	Call:
<p>Citigroup Medical Plan. If you're enrolled in an HMO, call your HMO directly.</p> <ul style="list-style-type: none">• Citigroup Dental Plan• Citigroup Vision Care Plan	<p>ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts to speak with a representative.</p> <p>From outside the United States: Call 972-652-4582.</p>

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer to employees and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events").

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You don't have to show that you're insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. *Citigroup reserves the right to terminate your coverage retroactively if you're determined to be ineligible under the terms of the Plan.*

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

Who's covered

You have a right to choose this continuation coverage if:

- You're enrolled in Citigroup medical, dental, or vision coverage and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under the FMLA, the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period.

If you're the spouse of an employee and are covered by a Citigroup-sponsored medical, dental, or vision Plan on the day before the qualifying event, you're a qualified beneficiary and have the right to elect continuation coverage for yourself if you lose coverage under a Citigroup-sponsored group health Plan for any of the following four reasons:

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

If you're a covered dependent child of an employee covered by a Citigroup-sponsored medical, dental, or vision Plan on the day before the qualifying event, you're also a qualified beneficiary and have the right to continuation coverage if you lose coverage under a Citigroup-sponsored group health Plan for any of the following five reasons:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
- The employee's divorce or legal separation;
- The employee's entitlement to Medicare; or
- You cease to be a "dependent child" under the Citigroup-sponsored medical, dental, or vision Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification of the birth or adoption to Citigroup.

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

Separate elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered

employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than that chosen by the employee.

Electing COBRA

To elect or inquire about COBRA coverage, call ConnectOne at 1-800-881-3938. From the main menu, choose the “health benefits” option and follow the prompts for a Benefits Service Center representative.

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

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

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months.

Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect. These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You should notify Citigroup if a second qualifying event occurs during your continuation coverage period.

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

Special rules for disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform Citigroup within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must inform Citigroup of this redetermination within 30 days of the date it was made, at which time the 11-month extension will end.

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

Medicare

If you lose coverage (medical, dental, or vision) due to your termination of employment or reduction in hours, your covered family member's COBRA coverage won't end before 36 months from the date you become covered by Medicare.

Early termination of COBRA

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated.

However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave, if you decide not to return to active employment you're still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

- When you definitively inform Citigroup that you aren't returning to work at the end of the leave or
- The end of the leave, assuming you don't return to work.

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

- You or your dependent is covered by the Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave) and
- You don't return to work at the end of the FMLA leave.

Your duties

Under the law, the employee or a family member is responsible for informing Citigroup of:

- A divorce or legal separation;
- Loss of a child's dependent status under the medical, dental, or vision Plan;
- An additional qualifying event (such as a death, divorce, legal separation, or Medicare entitlement) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the Social Security Administration (SSA) that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage of 18 months; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice *must* be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status, or an additional qualifying event. In the case of a disability determination, the notice *must* be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to Citigroup during this notice period, any individual(s) who loses coverage *won't* be offered the option to elect continuation coverage.

The notice must be in writing and must include the following information: The applicable Plan name, the identity of the covered employee and any qualified beneficiaries, a description of the qualifying event or disability determination, the date on which it occurred, and any related information customarily and consistently requested by the Plan's COBRA administrator.

If you're an employee of any Citigroup business in Puerto Rico, mail this notice to:

Jacksonville Benefits Service Center
P.O. Box 56710
Jacksonville, FL 32241-6710

When Citigroup is notified that one of these events has happened, Citigroup, in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify Citigroup and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child's loss of

dependent status, then you and your family members must reimburse the employer-sponsored Plans for any claims mistakenly paid.

Citigroup's duties

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

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

Cost of coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage.

The cost of group health coverage periodically changes. If you elect continuation coverage, Citigroup will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way.

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

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

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

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

You also may call the COBRA administrator at 1-800-422-7608.

Recovery provisions

Recovery provisions apply to the Citigroup Medical Plans and Dental Plans and are described in this section.

Refund of overpayments

Whenever payments have been made by the Plan for covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision, the

covered person(s) must make a refund to the Plan in the amount paid in excess of the amount payable under the Plan and help the Plan obtain the refund from another person or organization.

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

Reimbursement

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

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

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

The covered person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health Plan maintained by Citigroup or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, the covered person hereby:

- Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the covered person to the extent of all benefits provided in an effort to make the Plan whole; and
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage. The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.
- The covered person will cooperate with the Plan and its agents and will:
 - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
 - Provide any relevant information; and
 - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the covered person does not sign and deliver any such documents for any reason (including, but not limited to, the fact that the covered person was not given an agreement to sign or is unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the Plan

If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

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

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

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

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

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

Claims and appeals

If you don't receive a benefit to which you believe you're entitled under any Citigroup Health and Welfare Plan subject to ERISA (which excludes Optional GUL/Supplemental AD&D insurance), or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrator, as applicable. For more information about the Plan Administrator and Claims Administrator, see page 63.

If your claim is denied, you'll receive an explanation in writing detailing:

- The specific reasons for the denial;
- The specific references in the Plan documentation that support these reasons;
- The additional information you must provide to improve your claim and the reasons why that information is necessary; and
- The procedure available for a further review of your claim.

The Plan Administrator or Claims Administrator is generally required to evaluate your claim and notify you of its decision within a specified time period in accordance with ERISA. If your written claim is denied, you have a right to appeal the claim denied by the Plan Administrator or Claims Administrator by filing a request for review of your claim denial. If you wish to bring legal action against the Company or the Plan, you must first go through the Plan's appeals procedures.

The procedures governing claims for benefits, applicable time limits, and remedies available under the applicable Plan for the redress of claims that are denied are included in the Plan document, which is available at www.benefitsbookonline.com.

You also can call the Plan Administrator to request a copy of the Plan document without charge.

For enrollment-related claims only, you may file a claim with the Plans Administration Committee if your application to enroll is denied for the Medical Plans, Dental Plans, STD Plan, or LTD Plan. You may also file an appeal if your claim is denied by the Plans Administration Committee. To file an enrollment-related claim and for information on the claim review process, use the Health and Disability Benefits Eligibility Claims and Appeals Form available to you at no cost through your Benefits Service Center.

ERISA information

As a participant in Citigroup Health and Welfare Plans that are subject to ERISA (which excludes Optional GUL/Supplemental AD&D insurance), you have rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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

You may obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for copying the documents. You may receive a copy of the Plan's annual financial reports upon written request to the Plans Administration Committee.

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

You can reduce or eliminate an exclusionary period of coverage for pre-existing conditions under your group health Plan (if one exists), if you have creditable coverage from another plan.

You should be provided a Certificate of Creditable Coverage, free of charge, from your group health Plan or health insurance issuer:

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

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

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. For more information see the "Claims and appeals" section on page 61.

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

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

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

Answers to your questions

If you have questions about the Plan, contact the Plan Administrator.

If you have any questions about this book or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210.

The Employee Benefits Security Administration's New York City branch is located at 1633 Broadway, Room 226, New York, NY 10019.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Employee Benefits Security Administration or by accessing the Web site at www.dol.gov/ebsa/.

Administrative information

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

Future of the Plans

The Plans are subject to various legal requirements. If changes are required for continued compliance, you'll be notified.

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

In the event of the dissolution, merger, consolidation, or reorganization of Citigroup, the Plan will terminate unless the Plan is continued by a successor to Citigroup. If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

Plan administration

The Plan Administrator is responsible for the general administration of the Plans and has the full discretionary authority and power to control and manage all the administrative aspects of the Plans, except to the extent such authority has been delegated to the Claims Administrator.

In accordance with such delegation, the Plan Administrator and the Claims Administrator have the full discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits including the power and discretion to determine the rights or eligibility of employees and any other persons and the amounts of their benefits under the Plan and to remedy ambiguities, inconsistencies, or omissions and such determinations shall be binding on all parties.

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

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

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

Plan information

PLAN SPONSOR	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
EMPLOYER IDENTIFICATION NUMBER	52-1568099
PLAN ADMINISTRATOR	Plans Administration Committee of Citigroup Inc. c/o Corporate Compensation and Benefits 125 Broad Street, 8 th Floor New York, NY 10004
PLAN NAMES AND NUMBERS	
Medical Plan Triple-S	Citigroup Health Benefit Plan, Group # 1-03450
Dental Plan Triple-S	Citigroup Dental Benefit Plan, Group # 1-03450
Vision Care Plan	Citigroup Vision Benefit Plan
Prescription Drug Plan AdvancePCS	Group #6569
Basic Life insurance/AD&D Optional GUL/Supplemental AD&D	Citigroup Life Insurance Benefits, Plan #506 Citigroup Life Insurance Benefits
Citigroup Long-Term Care Insurance	Citigroup Long-Term Care Insurance #535
Short-Term Disability	Citigroup Salary Continuation (Short-Term Disability) Plan, Plan #529
Long-Term Disability	Citigroup Long-Term Disability (LTD) Plan, Plan #530
CLAIMS ADMINISTRATORS	
Each of the Claims Administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of their respective benefit Plan, namely, those provisions of the Plan document that apply to the participant and administered by that particular Claims Administrator. Since Optional GUL and Supplemental AD&D are not benefit plans subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.	
PLAN NAMES AND NUMBERS	
Preferred Provider Organization (PPO)	Triple-S PO BOX 363628 San Juan PR 00936-3628 (mailing address) 787-749-4777

Prescription Drug Program (retail pharmacy)	<p>AdvancePCS 9501 E Shea Blvd, MC018 Scottsdale, AZ 85260 654</p> <p>Muñoz Rivera Ave. Ste 1801 Hato Rey, PR 00918-4133 1-800-390-6441</p>
DENTAL PLAN	
Triple-S	<p>Triple-S P.O. Box 363628 San Juan PR 00936-3628 787-749-4777</p>
LIFE INSURANCE	
Basic Life	<p>Metropolitan Life Insurance Co. One Madison Ave. New York, NY 10010 1-800-638-6420</p>
Optional Life	<p>Metropolitan Life Insurance Co. One Madison Ave. New York, NY 10010 1-800-638-6420</p>
AD&D and Supplemental AD&D	<p>Life Insurance Company of North America 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000</p>
LONG-TERM CARE INSURANCE	<p>John Hancock Life Insurance Co. Group Long-Term Care, Floor X-3 529 Main St. Charlestown, MA 02129</p>
VISION Davis Vision	<p>159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U</p>
AGENT FOR SERVICE OF LEGAL PROCESS	<p>Citigroup Inc. General Counsel 399 Park Ave., 3rd Floor New York, NY 10043</p>

PLAN YEAR	January 1-December 31
FUNDING	
Medical Plan Dental Plan Vision Care Plan	<p>The Medical Plans and Dental Plans, (with the exception of the Vision Care Plan) are paid from the general assets of Citigroup and may be paid from a trust qualified under section 501(c)(9) of the IRC on behalf of the Plans in accordance with the terms of their Plan documents. The Vision Care Plan is funded through an insurance contract. The cost of Medical and Dental coverage is shared by Citigroup and the participant. The cost of the Vision Care Plan provided by employee contributions.</p> <p>The Claims Administrators don't guarantee the benefits under the Plan.</p>
Basic Life/AD&D Optional GUL/Supplemental AD&D	<p>The Basic Life/AD&D, Optional GUL/Supplemental AD&D, are fully insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life/AD&D coverage is provided through employer contributions; Optional GUL/Supplemental AD&D is provided through employee contributions.</p>
Short-Term Disability (STD)	<p>STD benefits are paid from the general assets of the Company and a trust qualified under section 501(c)(9) of the IRC in accordance with the terms of the Plan document. STD coverage is provided by Citigroup, and no employee contributions are required.</p>
Long-Term Disability (LTD)	<p>LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.</p>
Long-Term Care	<p>LTC benefits are fully insured.</p>
TYPE OF ADMINISTRATION	<p>The Plans are administered by the Plans Administration Committee. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.</p>

This book is intended to provide a brief overview of your benefits. Citigroup reserves the right to change or to discontinue any or all of the benefits coverage or programs described here at any time with or without notice. No statement in this or any other document and no oral representation shall be construed as waiving this right. The plan administrator has the sole discretion to interpret all of the provisions contained here, including the discretion to interpret the terms of eligibility for any of the benefits provided. Any such interpretation may only be relied upon if in writing from the plan administrator. Nothing in this or any other benefits documents or any oral representation should be construed as a guarantee of employment for any period of time.