Eligibility and Participation

This section describes the eligibility and participation rules for the following Citi benefit plans and programs:

- Health care coverage (medical, prescription drug, dental, and vision care);
- Spending accounts;
- Employee Assistance Program;
- Disability benefits; and
- Insurance (including Life and Accidental Death and Dismemberment [AD&D], Business Travel Accident/Medical, and Long-Term Care).

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Benefits overview

Citi provides a basic level of benefits coverage, called core benefits, as well as the opportunity to enroll in additional coverage for yourself and your family. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than for the core benefits, you must enroll to have coverage.

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

- **Basic Life and Accidental Death and Dismemberment (AD&D) insurance**, each equal to your total compensation, if less than $200,000, on your date of eligibility. Basic Life insurance is administered by MetLife, while AD&D is administered by CIGNA; if your total compensation is equal to or exceeds $200,000, you are not eligible for Basic Life/AD&D insurance;
- **Business Travel Accident/Medical insurance**, administered by ACE: business travel accident coverage of up to five times your total compensation to a maximum benefit of $2 million; and medical coverage related to covered accidents and/or sickness while traveling on behalf of Citi.
- **Employee Assistance Program (EAP)**, administered by Harris Rothenberg International LLC; a confidential, professional counseling service designed to help you and your family resolve issues that affect your personal lives or interfere with job performance;
- **Citi Live Well Program**, administered by Health Advocate and ActiveHealth; Citi's comprehensive health and wellness program provides you and your family with the tools and resources to manage your health care and help you achieve your health goals;
- **Short-Term Disability (STD) coverage**, administered by MetLife; 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 Citi; see "Short-term disability (STD)" in the *Disability* section of this document for the STD schedule of benefits that applies to you; and
- **Long-Term Disability (LTD) coverage**, administered by MetLife, equal to 60% of your total compensation, if your total compensation is less than or equal to $50,000.99.

Additional benefits to consider that require active enrollment:

- Benefits paid with pretax dollars:
  - Medical;
  - Dental;
  - Vision;
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA); and
  - Transportation Reimbursement Incentive Program (TRIP); see "Enrolling in TRIP" on page 8 for additional information.
- Benefits paid with after-tax dollars:
  - LTD, if your total compensation is $50,001 and above; if your total compensation is below this amount, LTD is a core benefit provided at no cost to you;
  - Group Universal Life (GUL) and Supplemental AD&D insurance; and
  - Long-Term Care insurance.

Enrolling in TRIP

The Transportation Reimbursement Incentive Program (TRIP) allows you to purchase transit/parking passes to use while traveling to and from work. You can enroll any time. *TRIP elections are not part of annual enrollment.*

Eligibility

Citi provides benefits coverage for you, your **spouse (whether same or opposite sex)**, **civil union partner** or **qualified domestic partner**, and/or **eligible dependents**.

For employees

You are considered an eligible U.S. Citi employee for health and welfare benefits if:

- You work in the United States for Consumer Banking, North America Cards, Institutional Clients Group, or Corporate Center or one of their participating businesses; and
- You are an active:
  - Full-time employee (regularly scheduled to work 40 hours or more a week) **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week); **and**
- You receive regular semimonthly or monthly pay and
- You are employed by a Participating Employer.
- A "participating employer" is Citigroup Inc. and any subsidiary in which Citi owns at least an 80% interest. Consumer Banking, North American Cards, Wealth Management, Institutional Client Group, and the Corporate Center are the Citigroup businesses that participate in the Plans.
- For purposes of determining whether you are an eligible employee under the Plans, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, or scheduled days off.

Note: If you are on an approved leave of absence, you are eligible to enroll in Citi benefits (other than the spending accounts, GUL, and Long-Term Care insurance); other enrollment restrictions may apply.

If both you and your spouse (whether same or opposite sex)/civil union partner/domestic partner are Citi employees

If both you and your spouse (whether same or opposite sex)/civil union partner/domestic partner are employed by Citi and are benefits-eligible, each of you can enroll individually or one of you can enroll and claim the other as a dependent. You cannot enroll as an individual *and* be claimed as your spouse's/civil union partner's/domestic partner's dependent.

- Medical, dental, and vision: Each of you may be covered under the medical and dental plans as either an employee or a dependent but not both. Either of you may cover your children, but they cannot be covered by both of you.
- Health Care Spending Account ("HCSA"): Either of you may be covered under a Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. However, your civil union partner, or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of section 152 of the Code as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- Limited Purpose Health Care Spending Account ("LPSA"): If either of you enrolls in the Citi Basic or Premier High Deductible Health Plan, you may be covered under the Limited Purpose Health Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. Neither of you can enroll in the HCSA, and you may be reimbursed only for dental, vision, or preventive care expenses under this account. However, your civil union partner or your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
- Employee Assistance Program: Both of you and your dependents will be covered under this program.

When you are not eligible to enroll

You are not eligible to enroll in the Plans if:

- Your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating business;
- You are employed by a Citi subsidiary or affiliate that is not a participating business;
- You are engaged under an agreement that states you are not eligible to participate in the applicable Plan or program;
- You are a non-resident alien performing services outside the United States; or
- You are classified by Citi as an independent contractor or consultant or are being employed on a temporary basis, hired with the intent to work fewer than six months, or you are not classified as an active full-time or part-time employee, as noted above.

If you are a U.S. citizen or legal resident employed outside the United States or if you are otherwise unsure whether you are eligible to participate in the Plans, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can also contact Human Resources for more information.

No pre-existing condition limitations

None of the Citi medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling in the Plans or receiving benefits for a specific condition or illness.

For dependents

Upon request, you must provide proof of your dependent's eligibility for coverage.

Your eligible dependents must be U.S. citizens or legal residents and generally are:

- Your lawfully married spouse (whether same or opposite sex), or your common-law spouse if you live in a state that recognizes common-law marriages, or your civil union partner, if you live in a state that recognizes such partnerships; if you are legally separated or divorced, your spouse is *not* an eligible dependent unless mandated by state law; you cannot cover both a spouse, a civil union partner, and a domestic partner;
  - Note that because civil union partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships are not subject to the domestic partnership certification process. However, under federal law, civil union partnerships are subject to the same tax treatment as domestic partnerships.
- Your domestic partner;
- Your domestic partner's eligible dependents;
  - To be eligible, the children of the civil union partner/domestic partner must meet all the qualifications of eligible dependent children as described in this section.
- Your unmarried children who rely on you for a majority of their financial support or who you claim as dependents on your federal tax return and are:
  - Your biological children;
  - Your legally adopted children;
    - For purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.
  - Your stepchildren who live with you full time in a regular parent-child relationship; if your spouse (whether same or opposite sex), civil union partner, or domestic partner has a court order to cover his/her children but the children do not live with you, you cannot cover them under the Plans; and
  - Any other child permanently living with you for whom you are the legal guardian in accordance with the laws of the state in which you reside.

Please note that not all HMOs cover civil union partners/domestic partners or their children. For more specific information, contact your HMO directly.

- **Note:** Each of your children who is unmarried and a "qualifying child" or "qualifying relative" as defined in section 152(c) and 152(d) of the Code, respectively, is an eligible dependent. Generally, a qualifying child up to the age of 18 must have the same principal place of residence as you for more than half the year, must not provide over one-half of his or her own financial support. A qualifying relative:
  - Will attain the maximum age of 19* as of the close of the plan year or
  - Will attain the maximum age of 25* as of the close of the plan year, and is a full-time student (meaning the student is enrolled full-time in courses for at least five months during the plan year) attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claim Administrator. The names, addresses and phone numbers of the health care Claim Administrators are listed under "Plan Information" in the *Administrative Information* section.

Generally, for you to have a qualifying relative as described above, **you** must be providing more than one-half of your child's financial support.

* Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs. You are required to notify the Plans when such events occur for your eligible dependents to be eligible for COBRA coverage. See the COBRA section for more information.

You can cover your unmarried children if they:

- Are under the age of 19; as of December 31 of the plan year that precedes the year for which coverage applies or
- Are under the age of 25 as of December 31 of the plan year that precedes the year for which coverage applies and are full-time students at an accredited school or college; or
- Were covered under the Plans before age 19, or age 25 as full-time students, and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age; or
- Were disabled adults when you began employment with Citi and you enrolled them when you were first eligible to do so; you must have a letter from the Social Security Administration declaring your child as disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your benefits.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. For more information on when coverage ends, see "When coverage ends" beginning on page 24.

Is your 19- to 25-year-old child a full-time student?

You can cover your 19- to 25-year-old child under your Citi benefits. During enrollment each year, you will be prompted to certify that your eligible child is a student; upon request, you must provide proof of student status in writing.

Effective January 1, 2010, if, as a result of a serious illness or injury, your child loses his or her status as a full-time student (for example, because he or she takes a leave of absence or changes to part-time status), he or she may continue to be covered under the Plan. Coverage can continue for up to 12 months from the date of the change in student status, unless your child loses eligibility for another reason, such as reaching the Plan's age limit.

State laws apply only to fully insured plans. See the list of fully insured plans in the "Medical" subsection of the *Health Benefits Plan* section of this document.

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. If your dependent child accepts a job at Citi and is benefits-eligible, you must drop your child from your coverage, regardless of whether your child chooses to enroll in his or her own coverage.

Note about disabled children: If one of your eligible dependent children is permanently and totally disabled as defined for purposes of obtaining Social Security benefits and (a) is covered under the Plans before reaching the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage.

For domestic partners

You are eligible to enroll your domestic partner who is a U.S. citizen or legal resident in Citi coverage if you are a U.S. employee who is active or on an approved leave of absence. For GUL or Long-Term Care insurance to be effective for your domestic partner, you must be actively at work.

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 have lived together for at least six consecutive months prior to enrollment; if you are married, the six months is counted beginning with the date your divorce is final or the date you report your divorce to the Citi Benefits Center, whichever is later;
- You are financially interdependent, or your partner is dependent on you for financial support;
- Neither you nor your domestic partner is legally married to another person; if you are married, legally separated, or getting divorced, you cannot add a domestic partner to your coverage until the later of six months from the date your divorce is final or the date you report your divorce to the Citi Benefits Center.
- Both of you are at least 18 years old and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex; **you cannot enroll your parents or siblings even though all other bullets may apply to your relationship**;
- Neither you nor your domestic partner is in a domestic partnership with anyone else;
- You have mutually agreed to be responsible for each other's common welfare; and
- You are in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

The Company may require you to provide proof of your financial interdependence (or domestic partner's financial dependence) by producing two or more of the following documents:

- A joint mortgage or lease;
- Designation of your domestic partner as beneficiary for life insurance or retirement benefits;
- Joint wills or designation of your domestic partner as executor and/or primary beneficiary;
- Designation of your domestic partner as your agent under a durable power of attorney or health proxy;
- Ownership of a joint bank account, joint credit cards, or other evidence of joint financial responsibility; or
- Other evidence of economic interdependence.

To cover a domestic partner, you and your domestic partner must first complete forms attesting to your domestic partnership. If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership. You can obtain the required documents by calling the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. **You must wait six months from the time your termination attestation form is received before you can add a new domestic partner.**

The children of your domestic partner are eligible for coverage if they are U.S. citizens or legal residents and they:

- Are the biological or adopted children of your domestic partner, children for whom your domestic partner has legal guardianship in accordance with the laws of the state in which you reside, or children who have 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 19 as of December 31 of the plan year that precedes the year for which coverage applies or
  - Are under the age of 25 as of December 31 of the plan year that precedes the year for which coverage applies and are full-time students at an accredited school or college;
  - Were covered under the Plans before age 19, or age 25 as full-time students, and became incapable of self-sustaining employment due to a disability, in which case the eligible children may be eligible for coverage beyond such age; or
  - Were disabled adults when you began your employment with Citi and you enrolled them when you were first eligible to do so.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. For more information on when coverage ends, see "When coverage ends" beginning on page 24.

HMO Eligibility

Please note that insured HMOs made available through the Citi Health Benefit Plan comply with state laws that require less restrictive age and/or income requirements for dependents. These laws apply only to insured health programs and do not apply to ChoicePlan 500 or other non-insured (self-funded) programs. States that have these laws include Colorado, Georgia, New Mexico, New Jersey, Pennsylvania, Tennessee, and Utah. For more information, contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

Other coverage

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

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits." See "Coordination of benefits" on page 34 for the guidelines on whose plan pays first.

Enrollment

You can enroll in Citi coverage within 31 days of the time you first become eligible or during the annual open enrollment period. The coverage available to you will be listed on your enrollment materials along with the enrollment deadline and how to enroll. You can enroll in any or all of the plans offered to you.

Coverage categories

Citi offers four coverage categories for medical and dental coverage:

- Employee Only: Coverage for you only;
- Employee Plus Spouse/Partner: Coverage for you and your spouse (whether same or opposite sex)/civil union partner/domestic partner only;
- Employee Plus Children: Coverage for you and your eligible children including the eligible children of your civil union partner/domestic partner; and
- Employee Plus Family: Coverage for you, your spouse (whether same or opposite sex)/civil union partner/domestic partner, your eligible children, and your civil union partner's/domestic partner's eligible children.

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

Each category has a different cost. In addition, your cost for medical coverage will depend on your total compensation band as defined in "Your contributions" on page 16. You will find your costs in your enrollment materials.

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

Changing your coverage category

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

As a new hire or newly eligible for benefits

As a new benefits-eligible employee, or if you are newly eligible for benefits, you will have 31 days from your date of eligibility to enroll in Citi benefits. *Enrolling in Citi health and welfare benefits is not mandatory.* If you do not enroll, you will have the core coverage, described above.

Dependent notification

The first time you enroll in Citi benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 19, whether the child is a full-time student or has a mental or physical disability.

You are required to provide the Social Security number of your dependents. However, if your dependent does not have a Social Security number at this time, you can call the Citi Benefits Center. Please note that not having a Social Security number on file may delay the timely payment of claims.

You also must keep your dependent information current:

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

Medical, dental, and/or vision coverage

You must enroll during your initial enrollment period to have coverage.

If you do not enroll

If you do not enroll in coverage within your initial 31-day enrollment period:

- You can enroll during a subsequent annual enrollment period or as the result of a qualified change in status.
- If you missed your enrollment deadline and later decided you want Citi coverage but do not want to wait until annual enrollment the following year, you may enroll in either one of the High Deductible Health Plans-Basic or Premier, MetLife Preferred Dentist Program (PDP), and/or the Vision Plan for the remainder of the calendar year. You must speak with a Citi Benefits Center representative to enroll. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" options.

During annual enrollment

Medical, dental, and/or vision coverage

If you do not enroll during a subsequent annual enrollment period you will be assigned the same coverage for the following year, or, if that coverage is no longer available, to comparable medical, dental, and/or vision coverage.

Health Care Spending Account/Limited Purpose Health Care Spending Account, and/or Dependent Day Care Spending Account

You must enroll each year to have coverage.

Long-Term Disability coverage

If your total compensation increases above $50,000.99 in any year, and you want LTD coverage for the following year, you must enroll during annual enrollment. Otherwise you will not have LTD coverage for the following year. (Evidence of good health will *not* be required at this time.) Company-paid LTD coverage is available only to employees whose total compensation is less than or equal to $50,000.99.

After you enroll or 'default'

Confirmation of enrollment

- **If you enroll by telephone by speaking with a representative:** A confirmation statement will be mailed to your home after your enrollment period ends. It will list your benefits elections and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment. If you find an error, immediately call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- **If you enroll online:** A confirmation statement will appear after you enroll and before you log out. Print and retain a copy as proof of your enrollment. If you enroll online during annual enrollment, a confirmation statement will be mailed to your home after your enrollment period ends. If you find an error, immediately call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Confirmation of default

If you do not enroll, you will have the "default" coverage shown on the Your Benefits Resources™ website, available through Total Comp @ Citi at **www.totalcomponline.com** or by going directly to **http://resources.hewitt.com/citigroup**. If you are a new hire, default coverage will also be shown on your Personal Enrollment Worksheet.

A default statement will be mailed to your home after your enrollment period ends. The default statement will list your default coverage.

Naming a beneficiary

Your beneficiary information should be on file with Citi. If you have never designated a beneficiary, visit the Your Benefits Resources™ website through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. From the "Quick Links" page, click on "Your Benefits Resources™." You also can go directly to Your Benefits Resources™ at **http://resources.hewitt.com/citigroup**. (Note that you need a user ID and password to access this site. If you do not have a user name and password, visit Your Benefits Resources™ at **http://resources.hewitt.com/citigroup**. See the Log On Help in the upper right.)

If you do not have intranet or Internet access, call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option. Speak with a Citi Benefits Center representative to name a beneficiary for Basic Life (including AD&D) insurance, Business Travel Accident/Medical insurance, Citigroup 401(k) Plan, and/or Citigroup Pension Plan.

If you enroll in Group Univesal Life (GUL) insurance, you must complete a MetLife Beneficiary Designation (Form 201) available on the Citi intranet at **www.citigroup.net/human_resources/form.htm** and return it to MetLife at the address on the form. You also can enroll or change your beneficiary at **www.metlife.com/mybenefits**. Your beneficiary for GUL insurance also is your beneficiary for Supplemental AD&D coverage.

If you change your beneficiary designation for either Basic Life or GUL, it will *not* 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 plans you may have until you designate other beneficiaries.

Your contributions

Your contributions for medical, dental, and vision coverage are based on the plan chosen and the coverage category. Your medical contribution also depends on your total compensation and which total compensation band applies to you. The required employee contributions for the medical plan increases as compensation increases. The compensation bands for 2010 are shown in the table below. Contributions for your Health Care Spending Account or your Limited Purpose Health Care Spending Account are determined by your contribution amount and not by your compensation band.

Total compensation bands on which employee contributions for medical coverage are based:

- $20,000 or less
- $20,001 – $25,000
- $25,001 – $40,000
- $40,001 – $60,000
- $60,001 – $80,000
- $80,001 – $100,000
- $100,001 – $150,000
- $150,001 – $250,000
- $250,001 +

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

Before-tax contributions

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

Social Security taxes

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

Total compensation and your benefits

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- GUL/Supplemental AD&D insurance and costs;
- Eligibility for the DCSA subsidy;
- STD for Account Executives in the Institutional Clients Group; and
- Business Travel Accident/Medical insurance benefits.

Definition of total compensation

If you are enrolling as a new hire or newly eligible employee

Your total compensation at the time you are hired is equal to your annual salary. If you are to be paid commissions only, your total compensation is calculated differently and is based either on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

For future years, your total compensation will be based on a formula that includes your actual base pay plus commissions, performance-based bonuses, and annual incentive bonus. **Note:** Your total compensation does not necessarily equal the amount reported as salaries and wages on your Form W-2 Wage and Tax Statement.

With respect to the current plan year, total compensation consists of (a) the annual rate of regular base pay as of June 30 of the calendar year which precedes the current plan year (the "Prior Year"); (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any cash bonus (other than the cash portion of any annual discretionary award package) paid during the calendar year which precedes the Prior Year; (d) any annual discretionary award/retention award package dated the Prior Year (including, if applicable, cash bonus, Capital Accumulation Program and deferred cash awards), and (e) short term disability benefits paid in the calendar year that precedes the Prior Year for employees paid commissions only.

For Wealth Management Financial Advisors

In your first year of employment, your compensation is considered to be $60,000. If you earned more than $60,000 at a previous employer in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 Wage and Tax Statement to your HR representative within 30 days of your hire date.

If you decide to provide a copy of the form, your Basic Life insurance amount, if applicable, will be set at the higher amount (up to $200,000, if your total compensation is less than $200,000) shown on the form. Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions also will be based on the higher amount.

Your decision to have your total compensation set at $60,000 or based on your Form W-2 amount is irrevocable.

The list of items that constitute total compensation under the Plan is exclusive, and shall not include any extraordinary payments, including but not limited to those related to settlements or forgivable loans or any other amounts, unless specifically set forth in the plan document or in an agreement or statement of policy approved or authorized by the Senior Human Resources Officer of Citigroup Inc. or his or her delegate.

If you are enrolling during the annual enrollment period

If you are enrolling during the annual enrollment period for coverage effective January 1, 2010, your total compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2009;
2. Commissions paid from January 1-December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1-December 31, 2008, will be used for the 2010 annual enrollment calculation;
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; cash bonuses paid in the period January 1-December 31, 2008, excluding the cash portion of the annual discretionary award package dated January 2008, will be used for the 2010 annual enrollment calculation;
4. Annual discretionary award/retention package dated in the year of enrollment (includes the following, if applicable: cash bonus, Capital Accumulation Program, and, deferred cash award; annual discretionary award/retention award packages dated January 2009 will be used for 2010 annual enrollment calculation; and
5. Short-Term Disability benefits paid from January 1, 2008-December 31, 2008, for employees paid on commissions only.

For new hires in the Institutional Clients Group: Any guaranteed bonus will be considered in the calculation of your total compensation for benefits purposes.

Domestic partner/civil union partner benefits

Citi offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. (You must submit a domestic partner coverage application before you can enroll a domestic partner or a domestic partner's child(ren) under your Citi coverage.) Citi also offers benefit coverage to your civil union partner.

You may cover your domestic partner/civil union partner and his or her eligible children under the following Plans:

- Medical,
- Dental;
- Vision;
- Health Care Spending Account, provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof (note: civil union partner/ domestic partners who do not meet section 152 cannot have their claims submitted for reimbursement into the Health Care Spending Account);
- Limited Purpose Health Care Spending Account, provided your domestic partner/civil union partner and his or her eligible children are considered tax dependents under Section 152 of the Code;
- GUL/Supplemental AD&D insurance for domestic partners/civil union partners and life insurance for children;
- Long-Term Care insurance.

You may enroll your domestic partner/civil union partner and his or her eligible children in the medical and/or dental Plan in which you enroll. You may enroll your domestic partner/civil union partner in spouse GUL/AD&D insurance, Long-Term Care insurance, and/or the vision Plan even if you do not enroll in those Plans.

Note: None of the Citi 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

You can enroll your domestic partner and his or her eligible children for Citi 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:

- Certifying your domestic partnership by submitting the Domestic Partner Coverage Forms;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

You must speak with a Citi Benefits Center representative to request the domestic partner coverage application forms. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" options.

Cost of civil union partner/domestic partner benefits

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

If your civil union partner/domestic partner and his or her child(ren) qualify as your dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, your contributions for civil union partner/domestic partner medical, dental, and/or vision coverage will be taken on a pre-tax basis. However, if your civil union partner/domestic partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, you will pay for their medical, dental, and/or vision coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your civil union partner/domestic partner in Citi coverage. This summary plan description does not address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, consult your tax adviser.

Along with your Affidavit of Domestic Partnership you will need to certify the tax status of your domestic partner and his or her children on the form.

If your civil union partner/domestic partner qualifies as a tax dependent

If your civil union partner/domestic partner and his or her children qualify as dependents under Section 152 of the Code, your contributions for their medical, dental, and/or vision coverage will be deducted from your pay before taxes are withheld, and there are no tax implications for you. Since the requirements are complex, consult your tax adviser for information on how civil union partnership/domestic partnership benefits will affect your taxes.

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

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

You may, but are not required, to certify whether your civil union partner and his/her dependent children qualify as dependents under Section 152 of the Code. If no certification is on file with Citi, the default is that the benefits are taxable.

If your civil union partner/domestic partner does not qualify as a dependent for tax purposes

Generally, medical, dental, and vision coverage are not taxable benefits if they are provided to you, your spouse, or your dependents. However, if your civil union partner/domestic partner and your partner's children do not qualify as your dependents for income tax purposes, the value of their coverage is considered income to you.

This additional income, known as "imputed income," will be shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. You will be required to pay taxes on this additional income, as required by the Internal Revenue Service (IRS).

Example: Total Citi cost for Employee Only coverage is $450 per month. Total Citi cost for Employee Plus Spouse/Domestic Partner/Civil Union Partner coverage is $900.

The $450 cost for partner coverage will be treated as taxable income to you. This amount is known as imputed income, and you will be taxed on this amount.

You will see a line item on your pay statement that shows $450 in imputed income. The taxable amount of that benefit (as determined by Citi's payroll department) will be deducted from your pay. In this example, $100 in taxes may be deducted from your pay for the $450 in imputed income.

If you terminate domestic partner coverage

You must complete a form attesting that your domestic partnership has ended to terminate domestic partner coverage. To request the form, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. Taxes paid on the imputed income are not refundable.

Your domestic partner will be eligible to continue medical, dental, vision, and/or Health Care Spending Account, if applicable, coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses, civil union partners and other covered dependents, excluding domestic partners and their children. See "COBRA" on page 29 for more information.

If you and your domestic partner marry

Report your qualified change in status to the Citi Benefits Center through ConnectOne, as instructed in the *For More Information* section, as soon as possible after your marriage and request that the imputed income be stopped. Otherwise, imputed income will continue to be calculated. Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

If your partner is of the same sex, imputed income will continue to be calculated unless your partner meets the definition of a Section 152 dependent. Consult your tax adviser.

Note: Changing your marital status and/or number of withholding allowances for payroll purposes will not stop imputed income from being calculated and taxes being withheld. You must call the Citi Benefits Center as instructed above, to report your marriage.

Changing your coverage

Qualified changes in status

The rules regarding qualified status changes apply to coverage elections you make for medical, dental, vision, Health Care Spending Account, and Limited Purpose Health Care Spending Account coverage. In general, the benefit plans and coverage levels you choose during annual enrollment remain in effect for the following calendar year. However, you may be able to change your elections between annual enrollment periods if you have a qualified status change or other applicable event, as explained below.

You must report to the Citi Benefits Center any change of status that affects your benefits within 31 days of the qualified event by following the process described under "How to report a qualified change in status event" below. (You also can review the Change in Status Worksheet and the Instructions for the Change in Status Worksheet, both available on the Citi intranet at **www.citigroup.net/human_resources/life_events.htm**.)

Exceptions to the 31-day rule are the loss of Medicaid or Children's Health Insurance Program (CHIP) coverage and the start of eligibility for state premium assistance. For these two events, you have 60 days to report a change of status and change your benefits.

Do not report qualified changes in status to your medical Plan. Your medical Plan must receive status change information from Citi, not from you.

Depending on the event, you may be permitted to:

- Enroll in or drop your medical, dental, vision, HCSA, LPSA, or DCSA coverage;
- Increase or decrease the amount of your HCSA, LPSA, or DCSA coverage;
- Enroll in LTD without having to provide evidence of good health;
- Enroll in or increase GUL/Supplemental AD&D insurance without having to provide evidence of good health. (For GUL, you may increase your existing coverage if the first, second, third, or sixth events below apply. Initial election of spouse/civil union partner/domestic partner or child coverage under this program is available if the first, second, or third events below apply.)

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

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

- **Dependent status**. Any event that causes your tax dependents to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence**. A change in the place of residence for you, your spouse, or another dependent if outside your medical or dental plan's network service area.

Coverage changes will be administered in accordance with applicable Treasury Regulations (Treasury Regulation section 1.125-4).

Consistency requirements

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

Effect on eligibility

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

Corresponding election change

The election change must correspond with the qualified status change. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may drop medical coverage only for that dependent. Additionally, you may increase or start contributions to a Health Care Spending Account or a Limited Purpose Health Care Spending Account if you add a dependent. The Plan Administrator will determine whether a requested change is due to a qualified status change and is consistent with the qualified status change.

Coverage and cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below. However, in no event will any cost or coverage event allow you to make a change to your Health Care Spending Account or your Limited Purpose Health Care Spending Account election.

Coverage events

If Citi adds or eliminates a plan option in the middle of the plan year, or if Citi-sponsored coverage is significantly limited or ends, you and your eligible dependents can elect different coverage in accordance with "IRS" regulations.

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

Also, if an election change is permitted during a different annual enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Citi), you may make a corresponding midyear election change.

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

Cost events

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

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

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

Other rules

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

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

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

Special Enrollment Rights: Effective April 1, 2009, if you or your dependents become eligible for premium assistance or lose eligibility for Medicaid or a state's Children's Health Insurance Program, you have special enrollment rights under the Plan. You must request coverage under the medical plans within 60 days of the noted occurrence.

How to report a qualified change in status event

You have 31 days from the date of the event to report a qualified change in status event and, if applicable, make changes to your and/or your dependent's coverage. To add a newborn child to your coverage, you must do so within 31 days of the child's birth.

To add a dependent, report the name, date of birth, and, if available, Social Security number for each dependent you want to add or remove from your coverage. If a newborn does not yet have a Social Security number, you must report all other information within 31 days and add the Social Security number once you obtain it.

Even if you are already enrolled in Citi family medical, dental, or vision coverage, you must report any new dependent; otherwise, your new dependent's claims will not be paid. *Do not report a new dependent to your medical/dental Plan.* Your Plan must receive the information from Citi, not from you.

When reporting a new dependent whom you wish to enroll in Citi coverage, you may have to change your coverage category. For example: You are enrolled in medical coverage under the "Employee Only" category and then you get married. If you want to cover your new spouse, you must report information about your new spouse *and* change from the "Employee Only" to the "Employee plus Spouse" coverage category.

To report a change in status, and, if applicable, change your coverage category and benefits:

- Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.
- Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
- To enroll in Group Universal Life (GUL) insurance, call MetLife at 1-800-523-2894.

Changing your coverage status

You must make changes to your health benefits within 31 days of a qualified status change by calling the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. The change will be effective on the date of your status change.

Change in Status Worksheet

Review the Instructions for Change in Status Worksheet (Form 308A) and the Change in Status Worksheet (Form 308B), which lists status events and the corresponding changes you can make to your benefits coverage for each event, at **www.citigroup.net/human_resources/life_events.htm** (intranet only).

Deadline to report qualified changes in status

You must report or revise dependent information and change your/your dependent's coverage or your coverage category within 31 days of the qualified event; o*therwise, you cannot change your or your dependent's coverage or your coverage category until the next annual enrollment period or until you have another qualified change in status, whichever comes first.*

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citi will pay benefits under the Health Benefit Plan (self-funded plans) for your newborn child from birth through 31 days. (**Note:** This eligibility provision does not apply to all insured plans; therefore, you should contact the plan for details). However, if you have coverage under any of Citi's Plans, you must report this family status change to the Citi Benefits Center within 31 days of the child's birth to add the child to your coverage.

If you do not report the addition of your child during the first 31 days, benefits will not be payable for the child after the 31 days following the date of the child's birth, and, generally, you will have to wait until the next annual enrollment period to enroll the child in the Plans unless another event occurs that would permit coverage to begin at an earlier time. In this case, no payment will be made for any day of confinement, treatment, services, or supplies given to the child after the initial 31 days after the child's birth. No other benefit or provision of the Health Benefit Plan will apply to the child.

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

- Extension of benefits and
- Continuation of coverage.

Remember, you must report information to the Citi Benefits Center about a new dependent even if you already have family coverage. Otherwise your new dependent won't be covered.

Plan changes you can make at any time

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

Long-Term Disability (LTD)

You can enroll at any time but you must provide evidence of good health except when enrolling as a new hire, when your total compensation increases above $50,000.99 (so that you must pay if you want to continue LTD coverage), or as a result of certain qualified changes in status.

The disability Plan will not cover any total disability caused by, contributed to, or resulting from a pre-existing condition until you have 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.

Group Universal Life (GUL)/Accidental Death and Dismemberment (AD&D) insurance

You can enroll in GUL coverage at any time. GUL coverage is administered by MetLife. MetLife does not require you to show evidence of good health to enroll:

- When first eligible (as a new hire or newly eligible for Citi benefits) if enrolling for up to three times the amount of your total compensation if the total is less than $1.5 million.
- For one times your total compensation as a result of losing Basic Life coverage because your total compensation was increased to $200,000 or above).

However, MetLife will require evidence of good health if you want to enroll:

- To enroll at any other time;
- To enroll for an amount three times greater than your total compensation or $1.5 million; or
- To increase the amount of your current coverage.

You must be actively at work before coverage will be effective.

CIGNA administers the AD&D portion of the benefit and does not require evidence of good health.

Long-Term Care insurance (LTC)

You can apply for coverage at any time for yourself; your eligible dependents may apply for themselves. You must be actively at work for coverage to be effective. Your eligible dependents must be not disabled on the date their coverage is to become effective. John Hancock will require evidence of good health before coverage is approved.

You can apply at any time. After your initial eligibility period you must provide evidence of good health and be actively at work before coverage will be effective. See the Long-Term Care insurance subsection of the *Insurance* section for more information.

Transportation Reimbursement Incentive Program

You can enroll to purchase a transit and/or parking pass online at any time. Enrollments/changes are effective as soon as administratively possible.

Health Savings Account

You can enroll or change your contribution at any time as long as you are enrolled in the High Deductible Health Plan-Basic or Premier.

When coverage begins

If:	Then:
You become eligible for Citi benefits coverage.	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your date of hire or date of eligibility.
You enroll for yourself and your eligible dependents during the annual enrollment period.	Coverage will begin on January 1 of the following year.
You enroll in medical, dental, vision, and/or spending account coverage for yourself or a new dependent within 31 days of a qualified status change.	Coverage for yourself or your dependent(s) will begin on the date of the qualified status change, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

When coverage ends

Your coverage under the Citigroup Health Benefit Plan, Dental Benefit Plan, and Vision Benefit Plan will terminate automatically on the earliest of the following dates:

- The date the Plan is terminated;
- The last day for which the necessary contributions are made;
- Midnight of the last day of the month in which your employment is terminated, you retire, you die, or you otherwise cease to be eligible for coverage;
- The date benefits paid on your behalf equal the lifetime maximum benefit under the Plan (coverage for eligible dependents who have not reached their lifetime maximum will not be affected); or
- Midnight of the last day of employment if your termination is due to gross misconduct.

Basic Life insurance coverage, Short-Term Disability, Long-Term Disability, and coverage under the Dependent Day Care Spending Account, Health Care Spending Account, and Limited Purpose Health Care Spending Account end on the date your employment is terminated. GUL and Supplemental AD&D insurance coverage ends on the last day of the month in which your employment is terminated.

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

- Midnight of the last day of the month in which your coverage ends; an exception is your death, in which case coverage will continue for six months;
- The date you elect to end your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date your eligible dependent ceases to be eligible for coverage; coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age); coverage will remain in effect through the end of the month in which the child gets married or obtains a benefits-eligible 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" beginning on page 29.

Coverage when you retire

You could be eligible for retiree health care coverage if:

- Your age plus completed years of service with Citi totals at least 60 and
- You have attained age 50 and have at least five years of Citi service.

For more information about eligibility for retiree medical coverage and the cost of coverage, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

A note for employees who were involuntarily terminated

The U.S. government has provided a COBRA subsidy for employees who are involuntarily terminated not for gross misconduct whose termination date **and loss of medical coverage occurred** on or after September 1, 2008 and before June 1, 2010, or as extended by subsequent legislation. To enable employees who are eligible for retiree medical, dental, and vision coverage to take full advantage of the government subsidy, Citi has provided special election rules. Under Citi's current programs, if (a) you are involuntarily terminated not for gross misconduct, (b) your termination date is on or after September 1, 2008 and before June 1, 2010, or as extended by subsequent legislation, **(c) your loss of medical coverage occurred on or after September 1, 2008 and before June 1, 2010, or as extended by subsequent legislation,** and (d) you meet the age and service requirements for retiree health coverage (medical, dental and vision) eligibility on your termination date, you have the following three options for your health care:

1. You may elect coverage under the active employee health plans through COBRA, or
2. You may elect coverage under the retiree health program (medical, dental, and vision) immediately, or
3. You may enroll in COBRA and elect retiree health coverage any time within your 18-month COBRA continuation period but not later than the end of such COBRA period. *If you don't enroll in retiree health coverage at or before the end of your COBRA period, you'll waive all rights to future enrollment in Citi retiree health coverage.*

Please note that, except in the very limited circumstances described below, you cannot enroll in coverage outside of Citi's plans and then enroll in Citi's retiree medical, dental or vision programs at a later date. For example, you cannot enroll in a spouse's plan then later elect Citi retiree health coverage. In order to defer Citi's retiree health coverage enrollment under the above rules, you must elect COBRA under Citi's plans.

However, if you are involuntarily terminated not for gross misconduct and your termination date **after May 31, 2010, or as extended by subsequent legislation** and you are eligible for the retiree health programs on your termination date, you must choose between electing retiree health coverage and COBRA. *If you elect COBRA,*

you will not be able to elect retiree health coverage at a later date.

In addition, if (a) you are eligible for coverage under the U.S. Separation Pay Plan, (b) you are projected to meet the age and service requirements for retiree health coverage eligibility within 12 months after your termination date and (c) you enroll in COBRA immediately following your termination date, you may elect to participate in Citi's retiree health program at any of the following times:

1. The date you would have met the age and service requirements for retiree health program eligibility had you remained employed;
2. If you elected COBRA, at any time during your COBRA continuation period after you have met such age and service requirements; or
3. If you elected COBRA, at the end of such COBRA period. *If you don't enroll in retiree health coverage at or before the end of your COBRA period, you'll waive all rights to future enrollment in the Citi retiree health program coverage.*

Alternatively, if (a) you are eligible for coverage under the U.S. Separation Pay Plan and (b) you are projected to meet the age and service requirements for retiree health coverage eligibility within 12 months after your termination date, but choose not to enroll in Citi COBRA coverage upon your termination, you will later have a one-time opportunity to enroll in Citi's retiree health programs at the time you meet the age and service requirements for Citi's retiree health programs, determined as if you had remained employed with Citi through such date.

If you are involuntarily terminated and are **not eligible** for coverage under the U.S. Separation Pay Plan, you must meet the age and service requirements for eligibility for retiree health coverage on your termination date to receive access to the retiree health programs; the 12-month rule described above is not available.

As always, Citi reserves the right to amend or terminate any of its plans and or coverage programs at any time.

Coverage if you become disabled

You and your eligible dependents may continue medical, dental, and vision coverage for up to 13 weeks as long as you make the active employee contributions. You may also continue to participate in the Health Care Spending Account or Limited Purpose Health Care Spending Account for 13 weeks or the end of the calendar year, whichever comes first.

If you are 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 the 13-week paid STD period, the Citi Benefits Center will bill you for your benefits. (The cost is not deducted from your LTD benefit.)

If your disability extends beyond 52 weeks, you may continue medical coverage for the lesser of a length of your disability or the medical continuation period, based on your years of service (as shown below).

Note: After 52 weeks of disability, your employment will be terminated.

Citi years of service as of the LTD effective date	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 are disabled or have not reached the maximum age limit to receive LTD benefits

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

The disability administrator will medically manage your disability if you are a totally disabled employee who has been denied LTD due to a pre-existing condition, did not enroll in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule, which is described in the LTD plan document.

If you are enrolled in a non-HMO medical Plan, once you become disabled for more than 29 months and are approved for Social Security disability, Medicare will become your primary medical coverage while benefits under the Citi 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. Then you may continue coverage under COBRA.

Vision: Coverage will continue for 52 weeks (including the 13-week period of STD) as long as you pay the active

employee contributions. Then you may continue coverage under COBRA.

Basic Life/Accidental Death and Dismemberment (AD&D): Coverage stops after 52 weeks, but you can convert your Basic Life/AD&D coverage to an individual policy by calling the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Group Universal Life (GUL) insurance: 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 GUL insurance. MetLife will bill you at the active employee rate for a length of time based on your years of service as shown in the table above. Your Supplemental AD&D coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits. You can convert your Supplemental AD&D coverage to an individual policy by calling the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Health Care Spending Account (HCSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit claims.

Limited Purpose Health Care Spending Account (LPSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit claims.

Dependent Day Care Spending Account (DCSA): Participation ends on your first day of STD. When you return to work from your approved disability, if you want coverage through the end of the year, you must re-enroll within 31 days of your return. Once re-enrolled, you can incur expenses through the end of the calendar year and will have until June 30 of the following calendar year to submit claims. You cannot be reimbursed for claims incurred while you were on a leave. With the exception of a military leave of absence, you cannot continue DCSA during a leave of absence.

Transportation Reimbursement Incentive Program (TRIP): Coverage ends on your first day of STD. When you return to work from your approved disability, you can re-enroll. You can be reimbursed for expenses incurred prior to your first day of STD. You must file claims for expenses within 12 months of the date on which the expense was incurred.

Coverage for surviving dependents

When an active employee dies, the surviving spouse and/or dependent children who were enrolled in active employee coverage at the time of the employee's death will be eligible to continue health care coverage through COBRA for six months at no cost.

If the employee was not eligible for retiree health care coverage at the time of death

Citi's COBRA administrator will send your dependents a COBRA notification package. For your dependents to have six months of free medical and/or dental coverage, they must elect COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center. See "COBRA" beginning on page 29.

If the employee was eligible for retiree health care coverage at the time of death

At the end of the free six-month period, as explained above, covered individuals either can continue COBRA coverage or elect retiree health care coverage. Retiree health care coverage is provided on the same terms as coverage provided to a retired employee.

Continuing coverage

During an FMLA leave

The Family and Medical Leave Act (FMLA) entitles eligible employees to take a job-protected leave for their own serious illness; the birth or adoption of a child; or to care for a spouse/civil union partner/domestic partner, child, or parent who has a serious health condition.

If you are eligible for an FMLA leave, 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 the FMLA, you may continue medical, dental, and vision coverage for yourself and your dependents and continue participating in the HCSA 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 will be billed directly.

If you lose any coverage during an FMLA leave because you did not 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 do not return to work at the end of your FMLA leave, you will be entitled to enroll in COBRA to continue your medical, dental, vision, and HCSA or LPSA coverage.

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

If you continue coverage during an FMLA leave, you will have access to the entire amount of your HCSA or LPSA annual election, less any reimbursements you have received. If you stop contributing, your participation in the HCSA or LPSA will be terminated while you are on an FMLA leave. In that case, you may not be reimbursed for any health care expenses you incur after your coverage was terminated.

If your HCSA or LPSA participation is terminated during your leave and you return to work during the same year in which your leave began, your contributions will resume. You can choose to resume contributions at the same level in effect before your FMLA leave or elect to increase your contribution level to make up for the contributions you did not make during your leave.

If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave.

Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you cannot use your HCSA or LPSA for expenses incurred during the period in which you did not participate.

Coverage if you take an unpaid leave of absence

If you go on an approved leave of absence, you may continue coverage under the medical, dental, vision, and health care spending account/limited purpose health care spending account. Your reduction in hours (less than 20 hours per week) constitutes a COBRA qualifying event under the plans. See “COBRA” on page 29 regarding continuation of coverage. You will pay at a rate under the plans determined under a policy established by the Committee or Citi.

Call the Citi Benefits Center through ConnectOne about your rights to continue medical, dental, vision, and HCSA or LPSA coverage. You will be billed directly. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the “health and welfare benefits” option.

Continuing coverage during a military leave of absence

The Citi Paid Military Leave of Absence Policy is updated from time to time. For the latest copy of the policy, visit **Citigroup.net** at **www.citigroup.net** (intranet only). 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 are entitled to continue your medical, dental, vision, DCSA, and HCSA or LPSA coverage at active employee rates for the length of your leave. Employee contributions will be deducted automatically from your pay.

The start of a military leave is considered a qualified change in status. As a result, you may stop coverage under any of the health and welfare benefit plans in which you are enrolled or, if you have not previously done so, you may enroll in certain coverage.

You must contact the Citi Benefits Center to enroll in or stop coverage. If you do not contact the Citi Benefits Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave with the exception of:

- TRIP participation, which stops automatically when your leave begins and
- STD, LTD, and Business Travel Accident/Medical insurance, which are suspended automatically when your leave begins.

You can participate in any annual enrollment periods that occur while you are on a military leave. If you are unable to make elections during annual enrollment, your elections will continue in effect until you return from your leave when you can make new elections for all health and welfare benefit Plans. If you elect to discontinue coverage while on a leave, you will have the right to re-enroll when you return to work.

Under the Heroes Earnings Assistance Relief Tax Act of 2008, if you are a reservist called to active military duty for more than 179 days on or after January 1, 2010, you are entitled to receive a taxable distribution of your Health Care Spending Account balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made such contributions.

Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can also contact your HR representative for more information about a military leave of absence.

Continuing coverage during military leave – no Citi policy

In the event Citi's Military Leave of Absence policy expires or otherwise ceases to remain in effect, you are still entitled to continue coverage for yourself and your eligible dependents under the Health Benefit Plan, the Dental Benefit Plan, the Vision Benefit Plan, and the HCSA/LPSA for the length of your leave up to 24 months in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as long as you give Citi notice of your leave as soon as practicable (advance notice, if possible). Your contributions would be made on an after-tax basis.

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

If you take a military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plan Administrator determines whether an exclusion or waiting period applies once you are reinstated to the plan. The Plan Administrator may take other steps to administer the Plans in accordance with USERRA and the Department of Labor regulations thereunder.

If you are on military leave for fewer than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage. Your eligibility for COBRA will begin on the date your leave ends. Call the Citi Benefits Center or contact your HR representative for more information about a military leave. For the Citi Benefits Center, call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (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 (called "qualifying events") where coverage under the Plan would otherwise end.

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

You do not have to show that you are insurable to elect continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage.

Citi reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the Plan.

You must pay the entire contribution (employee plus employer cost) plus a 2% administration 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 to your first payment.

Who is covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in Citi medical, dental, vision, or HCSA or LPSA 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 Family and Medical Leave Act (FMLA) the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave; (b) the date that you do not return to work after the leave; or (c) the last day of the FMLA leave period.

If you are the spouse (or civil union partner/domestic partner) of an employee and are covered by a Citi-sponsored medical, dental, or vision Plan (or your claims can be reimbursed through your spouse's HCSA or LPSA) and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

1. The death of your spouse;
2. 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;
3. Divorce or legal separation from your spouse; or
4. Your spouse's entitlement to Medicare.

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

1. The death of the employee;
2. 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;
3. The employee's divorce or legal separation;
4. The employee's entitlement to Medicare; or
5. You cease to be a "dependent child" under the Citi-sponsored medical, dental, or vision Plan or HCSA or LPSA.

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 also is 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 to Citi of the birth or adoption.

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

Separate elections

Each qualified 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 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. A spouse or dependent child may elect different coverage from that chosen by the employee.

Electing COBRA

To inquire about COBRA coverage, speak to a Citi Benefits Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Several weeks after your COBRA-qualifying event, you automatically will receive COBRA election information from Citi's COBRA administrator. Citi considers the date of the qualifying event as the last day of the month in which your employment was terminated or other qualifying event occurred. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described above, or, if later, 60 days after Citi 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, Citi 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. 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 a minimum of 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

COBRA continuation coverage is available for your spouse and eligible dependents for up to 36 months when the qualifying event is the death of the covered employee, divorce or legal separation, the covered employee becoming entitled to Medicare, or a dependent child's loss of eligibility as a dependent child.

Additional qualifying events may occur while the continuation coverage is in effect. Examples of such events are the death of the covered employee, divorce, legal separation, the covered employee becoming entitled to Medicare, or a dependent child's loss of dependent status after an initial qualifying event, such as loss of employment.

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify the Citi Benefits Center if a second qualifying event occurs during your continuation coverage period. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

When COBRA medical coverage ends, generally you cannot convert your coverage to an individual medical policy.

Special rule for HCSA and LPSA

Unless required by law, continuation coverage for HCSA and LPSA will not be available beyond the end of the year in which the qualifying event occurs.

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 (SSA) 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 of employment or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform Citi within 60 days of the SSA determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the SSA determines that the qualified beneficiary is no longer disabled, the individual must inform Citi of this redetermination within 30 days of the date it is made at which time the 11-month extension will end.

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

Medicare

If you become entitled to Medicare and, within 18 months after becoming entitled to Medicare, you subsequently lose coverage (medical, dental, vision, or HCSA or LPSA coverage) due to your termination of employment or reduction in hours, your eligible dependents' COBRA coverage will not end before 36 months from the date you became entitled to Medicare. However, your eligible dependents' COBRA coverage will not extend beyond 36 months.

Early termination of COBRA

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

1. Citi no longer provides group health coverage to any of its employees;
2. The premium for continuation coverage is not paid on time (within the applicable grace period);
3. The person who elected COBRA 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 covered individual;
4. The person who elected COBRA becomes entitled to Medicare after the date COBRA is elected; or
5. Coverage has been extended for up to 29 months due to disability, and the disability carrier makes a final determination that the individual is no longer disabled.

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 or you decide not to return to active employment you are 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 Citi that you are not returning to work at the end of the leave or
- The end of the leave, and you do not return to work.

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

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

Your duties

Under the law, the employee or a family member is responsible for notifying Citi of:

- A divorce or legal separation;
- The loss of a child's dependent status under the medical, dental, or vision Plan or HCSA or LPSA;
- An additional qualifying event (such as a death, divorce, or legal separation) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the 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 Citi during this notice period, any individual(s) who loses coverage will not 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. Mail this information to the address below if the covered person is an active employee of Citi:

Citi Benefits Center
2300 Discovery Drive
P.O. Box 785004
Orlando, FL 32878-5004

When Citi is notified that one of these events has occurred, Citi, in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify Citi 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 may be required to reimburse the Plans for any claims mistakenly paid.

Citi's duties

If any of the following events results in a loss of coverage, qualified beneficiaries will be notified of the right to elect continuation coverage automatically without any action required by the employee or a family member:

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

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 will be required to pay 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, Citi 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.

As noted earlier, in "Coverage when you retire" on page 25, under the U.S. government subsidy, employees who are terminated involuntarily (not for gross misconduct) and lose medical coverage on or after September 1, 2008 and before June 1, 2010, or as extended by subsequent legislation, may be eligible for a subsidy of 65% of their COBRA premium for up to fifteen months of the 18 month COBRA continuation period, if certain criteria are satisfied. In general, single individuals with adjusted gross income below $125,000 (or below $250,000 for married couples filing jointly) may be eligible for the full COBRA subsidy.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator at the address below. If the covered person has terminated employment with Citi and your marital status has changed or you or a qualified beneficiary 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 below.

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

Citi Benefits Center
2300 Discovery Drive
P.O. Box 785004
Orlando, FL 32878-5004

You also may call the COBRA administrator through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

Coordination of benefits

All payments under these Plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citi Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Health Benefit Plan (which includes medical and prescription drug coverage), the Citigroup Dental Benefit Plan, and the Citigroup Vision Benefit 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.

The following definitions apply to terms used in this section:

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

When you are 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 Citi Plan is primary:** The Citi Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first. Benefits will be calculated according to the terms of the Plan and will not be reduced due to benefits payable under other plans.
- **When the Citi Plan is secondary:** Benefits under the Citi Plan may be reduced. The Claim Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan than the Citi Plan would have paid alone.

  When the Citi Plan is secondary and the patient is covered under an HMO, benefits under the Citi Plan will be limited to the coinsurance, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO. If a service is not covered or coverage is denied, you will be responsible for payment.

The Citi Plan will be the primary plan for claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children.

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 legal separation

When a child is claimed as a dependent by parents who are legally 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 Citi 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:

1. The plan of the parent with custody of the child;
2. The plan of the spouse of the parent with custody of the child; and
3. 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 does not have a coordination-of-benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered primary.

Coordination with Medicare

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

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citi Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

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

No-fault automobile insurance

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

Facility of payment

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

Right of recovery

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

- Any persons it paid or for whom payment was made;
- Any insurer, and any other organization; or
- Any entity that was thereby enriched.

Release of information

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

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

How to file a claim

Most medical and dental benefits are paid directly to the providers. Listed below are the forms needed to claim benefits that are not paid directly. If you do not receive benefits to which you believe you are entitled, see the applicable "Claims and appeals" subsection in the section that describes each plan.

Name of Plan	Name/form number and when to use the form	How to obtain a form
Aetna ChoicePlan 500 High Deductible Health Plan - Basic and Premier	Aetna Medical Benefits Request (Form 301) Use the form to file a claim for covered out-of-network expenses.	Visit the "Forms" section of the Citi intranet at **www.citigroup.net/human_resources/life_events.htm**. Or Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links page, click on "Your Benefits Resources™." You also can go directly to **http://resources.hewitt.com/citigroup**.
Empire BlueCross BlueShield ChoicePlan 500	Health Insurance Claim Form for the ChoicePlan (Form 322) Use the form to file a claim for covered out-of-network expenses.	
UnitedHealthcare (Hawaii Health Plan)	Citigroup Health Claim Transmittal (Form 303) Use the form to file a claim for covered out-of-network expenses.	
Oxford Health Plans PPO	Oxford Health Insurance Claim Form (Form 309) Use the form to file a claim for covered out-of-network expenses.	
MetLife Dental	MetLife Dental Claim Form (Form 304) Use the form to file a claim for covered dental expenses.	
Express Scripts	Express Scripts Prescription Drug Claim (Form 310) Use the form to file a claim for a covered out-of-network expenses.	In addition to the instructions at the top of this column, call Express Scripts at 1-800-227-8338 or visit **www.express-scripts.com**.
Health Care Spending Account (HCSA)	If you do not use your Spending Account Reimbursement Card, you can file a claim using the HCSA Reimbursement Request Form (Form 316). Use the form to submit eligible health care claims for reimbursement.	Visit the "Forms" section of the Citi intranet at **www.citigroup.net/human_resources/life_events.htm**. Or Visit Your Benefits Resources™ through Total Comp @ Citi at **http://www.totalcomponline.com**. From the "Quick Links page, click on "Your Benefits Resources™." You also can go directly to **http://resources.hewitt.com/citigroup**.
Limited Purpose Health Care Spending Account (LPSA)	LPSA Reimbursement Request Form (Form 315) Use the form to submit eligible vision, dental, or preventive care health care claims for reimbursement.	
Dependent Day Care Spending Account (DCSA)	DCSA Reimbursement Request Form (Form 317) Use the form to submit eligible dependent care claims for reimbursement.	
Transportation Reimbursement Incentive Program (TRIP)	Transportation Reimbursement Incentive Program Claim Form (Form 306) Effective in early 2010, you must order your transit and/or parking pass/ticket online. No paper claims will be reimbursed.	

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

- Medical, dental, and vision claims must be filed within two years of the date of service. If you participate in an HMO, call your HMO for its claim-filing deadlines.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA claims must be filed by June 30 following the year in which the expense was incurred.
- LPSA claims must be filed by June 30 following the year in which the expense was incurred.
- DCSA claims must be filed by June 30 following the year in which the expense was incurred.