Eligibility and participation

Your Citi health and welfare benefits are a valuable part of the rewards of working at Citi. To make the most of your benefits, you need to understand how they work. This section describes the eligibility and participation rules for the following Citi benefit plans and programs:

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

Section contents

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 American Insurance Company, 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;
- **Work/Life Program**, administered by Health Advocate; provides assistance and helps employees save time as they face common everyday challenges, such as finding child care, free legal assistance, help with identity theft, and more;
- **Short-Term Disability (STD) coverage**, administered by MetLife; coverage to replace generally 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 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, provided your total compensation is less than or equal to $50,000.99.

Additional benefits to consider that require active enrollment:

- Benefits paid with before-tax dollars (as long as you are receiving a paycheck):
  - Medical (including the Health Savings Account (HSA) if you are enrolled a High Deductible Health Plan);
  - 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).
- 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.

Eligibility

Citi provides benefits coverage for you, your spouse (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 or more hours a week); **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week); **and**
- You receive regular biweekly 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 America 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 your eligibility for certain benefits may change. Refer to the "Continuing coverage" section within this document for additional details.

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

If both you and your spouse (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.

Plan	Applicable rules
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 as 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 contribute to 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, either of you may contribute to a LPSA 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. 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.
Health Savings Account ("HSA")	The maximum amount that can be contributed to an HSA for the 2012 calendar year is $6,250 for family coverage. This does not mean that both family members can contribute $6,250 each, it is a combined contribution amount. Citi makes up to a $1,000 annual contribution for employees with family coverage and up to $500 for individual coverage.
Dependent Day Care Spending Account ("DCSA")	Either of you may contribute to a Dependent Day Care Spending Account but you may not file more than once for reimbursement of the same eligible expense. 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.

Eligibility and participation

Plan	Applicable rules
Transportation Reimbursement Incentive Program ("TRIP")	Spouses (same or opposite sex)/civil union partner/domestic partner are not eligible to enroll in TRIP.
Group Universal Life ("GUL") / Supplemental AD&D	Each of you may be covered under the GUL plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Live Well Credits	**Health Assessment:** Rewards for you and your spouse (same or opposite sex)/domestic partner/civil union partner will be applied to the employee that has medical coverage for the company couple. If neither of the couple has medical coverage, then dental or vision will be used to determine appropriate assignment of this reward. **Tobacco Free:** You and your spouse (same or opposite sex)/domestic partner/civil union partner should coordinate your elections so the "Spouse Tobacco Free Reward Attestation" is elected on the account of whoever has elected medical, dental or vision coverage. **Note:** If Tobacco Free Reward Attestation is elected both as a "Spouse Tobacco Free Reward Attestation" and "Employee Tobacco Free Reward Attestation", then the "Spouse Tobacco Free Reward Attestation" Reward will be removed from your account.
Employee Assistance Program ("EAP")	Both you and your eligible dependents are 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 you are 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 described above.

If you are not eligible for benefits pursuant to the above and are subsequently reclassified as, or determined to be, an employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or any other individual or entity, or if Citi is required to reclassify you as an employee as a result of such reclassification or determination (including any reclassification in settlement of any claim or action relating to your employment status), you will not become eligible to participate in the Plan by reason of such reclassification or determination retroactively. If a person who is not classified by Citi as an eligible employee otherwise satisfies these eligibility rules and is subsequently reclassified by Citi as an eligible employee, such person, for purposes of these Plans, shall be deemed an eligible employee from the later of the actual or the effective date of such reclassification.

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

When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

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

- Irrespective of sex, your lawfully married spouse, or your common-law spouse if you live in a state that recognizes common-law marriages, same or opposite sex, 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; at any time, you cannot cover more than one person as your spouse/civil union partner or domestic partner.
  - **Note:** 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. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the listed requirements for nonregistered domestic partners.
- Your domestic partner;
- Your domestic partner's eligible dependents;
- Your children up to age 26 who 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; and
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your disabled child beyond age 26 if he or she was covered under the Plans before age 26 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.

You may also cover your disabled adult child age 26 or older when you begin employment with Citi and you enroll him or her when you are first eligible to do so. You must have a letter from the Social Security Administration (SSA) 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 health care coverage.

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

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For specific information, contact your HMO directly. For more information on when coverage ends, see "When coverage ends" beginning on page 31.

State laws apply only to fully insured plans. See the list of fully insured plans in the Medical subsection of the Health care benefits section of this Benefits Handbook.

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.

Note about disabled children: If your eligible dependent child 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 or 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, including, but not limited to, continuing to be permanently and totally disabled.

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 if your domestic partnership is registered in any state or under any local government authorized to provide such registration, your registration will be accepted as proof of your domestic partnership, or 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, legally separated or getting a divorce, 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, marriage, or civil union 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. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the previously listed requirements. If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership. Alternatively, if your registration (as noted above) is terminated or no longer effective pursuant to state law or local government authority, documentation to that effect will be accepted as proof of 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, are under age 26 as of December 31 of the plan year that precedes the year for which coverage applies, and they are your domestic partner's:

- Biological children;
- Legally adopted children;
- Stepchildren; and
- Any other child for whom your domestic partner is the legal guardian in accordance with the laws of the state in which he or she resides.

You can cover your domestic partner's disabled child beyond age 26 if he or she was covered under the Plans before age 26 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.

You can also cover your domestic partner's disabled adult child when you begin employment with Citi and you enroll him or her when you are first eligible to do so. You must have a letter from the Social Security Administration declaring your domestic partner's 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.

For Long-Term Care insurance, dependents must be age 10 or older. See the 'Insurance' section for more information

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age. 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 31.

HMO eligibility

Please note that insured HMOs made available through the Citigroup 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. This applies to the following plans:

1. Coventry Health Care of Iowa;
2. Geisinger Health Plan (Pennsylvania);
3. Health Plan Hawaii Plus (HMSA);
4. SelectHealth (Utah and part of Idaho);
5. Independent Health (upstate New York);
6. Kaiser FHP of California - Northern;
7. Kaiser FHP of California - Southern;
8. Kaiser FHP of Colorado;
9. Kaiser FHP of Georgia;
10. Kaiser FHP of Hawaii;
11. Kaiser FHP of the Mid-Atlantic States;
12. Presbyterian Health Plan (New Mexico); and
13. Sanford Health Plan (South Dakota).

For more information, use the information on "Health care plan offered by Citi" to 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/domestic 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 40 for the guidelines on whose plan pays first.

Health Advocate

Health Advocate can help you understand your benefits and compare the costs and benefits of different plans. Call **1-866-449-9933** and select option #2 to speak with your Personal Health Advocate.

Enrollment

You can enroll in Citi coverage within 31 days of the time you first become eligible or during the annual enrollment period. Your enrollment materials will contain the coverage available to you, 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 (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 (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 from his or her employer 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 21. 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. See "Changing your coverage" beginning on page 25 for more information.

As a new hire or newly eligible for benefits

As a newly-hired 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.* You must enroll during your initial enrollment period to have voluntary benefits, including medical, dental and vision coverage. You must also enroll to participate in a Health Care Spending Account, Limited Purpose Health Care Spending Account, Health Savings Account, Dependent Day Care Spending Account or the Transportation Reimbursement Incentive Program. If you do not enroll, you will have the core coverage, described in "Benefits overview" on page 12.

Dependent notification

The first time you enroll new dependents 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 26, whether the child has a mental or physical disability. You will also be required to submit proof of the dependent's eligibility for coverage. For more information on the dependent verification process, see "For dependents" on page 14, under "Eligibility" on page 13.

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

You must also keep your dependent information current:

- When you enroll during the annual enrollment period, you can change your dependent information; and
- When you change your coverage or coverage category as a result of a qualified status change, you must notify the Citi Benefits Center of any updates in dependent information.

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.

During annual enrollment

If you want to enroll in Citi coverage, drop Citi coverage, change to a different medical, dental, or vision option, or change your coverage category — for example from single to family or viceversa — you must do so during your enrollment period. Outside of annual enrollment, you can only make changes to your coverage if you have a qualified change in status.

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.

Health Savings Account

You are eligible to participate in a Health Savings Account if you are enrolled in a High Deductible Health Plan. Initially, you must accept the Terms and Conditions of the program to complete your enrollment. Once the Terms and Conditions have been accepted you only need to enroll each year to have coverage.

Basic Life/AD&D Coverage

If your total compensation, for benefits purposes, increases to $200,000 or above effective January 1, 2012, you'll be ineligible for company-paid Basic Life/AD&D coverage. However, if you have not previously elected the maximum coverage under Group Universal Live (GUL) insurance, during annual enrollment you'll have the opportunity to enroll in GUL insurance equal to one times your total compensation, not to exceed $500,000, without providing proof of good health.

Long-Term Disability coverage

If, as a newly hired employee, your total compensation exceeds $50,000.99, you may be automatically enrolled in LTD coverage with an option to decline coverage, described below. If your total compensation, for benefits purposes, increases above $50,000.99 in any plan year, you may be automatically enrolled in LTD coverage for the following year during annual enrollment with payroll deductions beginning January 1. (Evidence of good health will *not* be required at this time.)

If you do not want LTD coverage, you may choose "no coverage" when you make your elections during annual enrollment (or enroll as a new hire). However, if you do not make an election, you will be automatically enrolled in LTD coverage. You may elect to retroactively decline coverage for up to 90 days after January 1 (or 90 days after enrollment as a new hire), and receive a refund of premiums paid. You may elect to decline coverage prospectively after the initial 90-day period passes; however, you will not receive a premium refund.

Company-paid LTD coverage is available only to eligible 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 permanent address on file 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. A confirmation statement will be mailed to your permanent address on file 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 confirmation statement will be mailed to your home after your enrollment period ends. The confirmation 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 and click on "Beneficiary designation." You can also 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 Universal Life (GUL) insurance, you must complete a MetLife Beneficiary Designation (Form 201) available on **Citi For You** (intranet only) and return it to MetLife at the address on the form. You can also enroll or change your beneficiary by visiting Total Comp @ Citi at **www.totalcomponline.com** and clicking on "Dental/Disability/Group Universal Life (GUL)." Your beneficiary for GUL insurance is also 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 and the coverage category you elect. Your medical contribution also depends on the total compensation band that applies to you. The employee contributions for the medical plan increase as total compensation increases. The compensation bands for 2012 are shown below.

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

- $30,000 or less
- $30,001 – $50,000
- $50,001 – $100,000
- $100,001 – $200,000
- $200,001 +

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

Before tax contributions

Contributions for medical (including the HSA), dental, vision care, and spending accounts are made with before-tax dollars as long as you are receiving a paycheck. This means your contributions are deducted from 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. However, these before-tax contributions may 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 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;
- Long-Term Disability (LTD) benefits and, where applicable, LTD contributions;
- Basic Life/Accidental Death and Dismemberment (AD&D) insurance benefits;
- Optional Group Universal Life (GUL)/Supplemental AD&D insurance and costs;
- Eligibility for the Dependent Day Care Spending Account subsidy;
- Short-Term Disability benefits 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 base 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:

For the current plan year, total compensation consists of:

- Annual base pay as of June 30, 2011;
- 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, 2010 -December 31, 2010, will be used for the 2012 annual enrollment calculations;

- Cash bonuses (other than the cash portion of any annual discretionary incentive/retention award package) paid in the period January 1-December 31 in the year prior to enrollment; cash bonuses paid in the period January 1, 2010-December 31, 2010, excluding the cash portion of the annual discretionary incentive/retention award package dated January 2010, will be used for the 2012 annual enrollment calculations;
- Annual discretionary incentive/retention award package dated in the year of enrollment; includes the following, if applicable: (Cash Bonus, Incentive Stock Payment Program (ISPP) Award, CAP Award); annual discretionary incentive//retention award packages dated January 2011 will be used for the 2012 annual enrollment calculations;
- Guaranteed Bonus effective in the current year (2011);
- Short-Term Disability benefits paid from January 1-December 31, 2010, for employees paid on commissions only.
- Salary Stock paid on any of the following four dates: September 30, 2010, October 29, 2010, November 30, 2010, or December 30, 2010; and
- Long-Term Restricted Stock (LTRS) awarded on January 18, 2011.

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 shown on the form. (Basic Life is available only to those employees whose total compensation is less than $200,000.) Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions will also 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, 2012, your total compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2011;
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, 2010, will be used for the 2012 annual enrollment calculation;
3. Cash bonuses (other than the cash portion of any annual discretionary incentive 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, 2010, excluding the cash portion of the annual discretionary incentive award package dated January 2010, will be used for the 2012 annual enrollment calculations;
4. Annual discretionary incentive/retention award package dated in the year of enrollment includes, as applicable, cash bonus, Incentive Stock Payment Program (ISPP) Award, Capital Accumulation Program (CAP) Award. Annual discretionary incentive/retention award packages dated January 2011 will be used for the 2012 annual enrollment calculation;
5. Guaranteed bonus effective in 2011;
6. Short-Term Disability benefits paid from January 1, 2010-December 31, 2010, for employees paid on commissions only;
7. Salary stock paid on any of the following four days: September 30, 2010, October 29, 2010, November 30, 2010, or December 30, 2010; and
8. Long-Term Restricted Stock (LTRS) awarded January 18, 2011.

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/same sex spouse 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 or your registration, as applicable, before you can enroll a domestic partner or a domestic partner's child[ren] under your Citi coverage.) Citi also offers benefits coverage to your civil union partner/same sex spouse.

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

- Medical;
- Dental;
- Vision;
- Health Care Spending Account, provided your domestic partner/civil union partner/same sex spouse 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 partners/domestic partners/same sex spouses who are not considered tax dependents under Section 152 cannot have their claims reimbursed under the Health Care Spending Account);
- Limited Purpose Health Care Spending Account, provided your domestic partner/civil union partner/same sex spouse 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;
- Dependent Day Care Spending Account, provided your domestic partner/civil union partner/same sex spouse 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;
- GUL/Supplemental AD&D insurance for domestic partners/civil union partners/same sex spouses and life insurance for children;
- Long-Term Care insurance.

You may enroll your domestic partner/civil union partner/same sex spouse 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/same 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 in 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 during the plan year are:

- Submitting your registration or 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 Forms. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" options.

For information on domestic partner eligibility, see "For Domestic Partners" under "Eligibility."

Cost of civil union partner/domestic partner/same sex spouse benefits

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

If your civil union partner/domestic partner/same sex spouse 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/same sex spouse medical, dental, and/or vision coverage will be taken on a before-tax basis. However, if your civil union partner/domestic partner/same sex spouse 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/same sex spouse in Citi coverage. This Benefits Handbook 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.

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

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

If your civil union partner/domestic partner/same sex spouse and his or her children qualify as 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 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/same sex spouse benefits will affect your taxes and those of your civil union partner/domestic partner/same sex spouse.

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/domestic partner/same sex spouse and his or her dependent children qualify as dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2), and d(1)(B) thereof. If no certification is on file with Citi, the benefits are considered taxable.

If your civil union partner/domestic partner/same sex spouse 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/same sex spouse and your partner's children do not qualify as your dependents for income tax purposes, the value of their coverage is considered taxable 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 Code.

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 (known as imputed income) will be treated as taxable income to you.

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

To terminate domestic partner coverage, you must complete a form attesting that your domestic partnership has ended, or submit a document showing the termination of your domestic partner registration, as applicable. 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 coverage, if applicable, at his or her expense for a period of 36 months.

This coverage will be similar to Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) coverage offered to spouses, civil union partners, and other covered dependents, excluding domestic partners and their children. See "COBRA" beginning on page 36 for more information.

If you and your domestic partner marry

Report your qualified change in status to the Citi Benefits Center as soon as possible after your marriage and request that the imputed income be stopped. You will be required to provide proof of the marriage in order to stop the assessment of imputed income permanently. 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 dependent under Section 152 of the Code. 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 changes in status apply to coverage elections you make for medical, dental, vision, Health Care Spending Account, Limited Purpose Health Care Spending Account coverage, Dependent Day Care Spending Account, Long-Term Disability, Supplemental AD&D, and Group Universal Life insurance. 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" on page 28.

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 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 you marry, establish an eligible domestic partnership, or in the event of the birth or adoption of a child.)

Examples of qualified changes in status are:

1. Your marriage, legal separation, or divorce;
2. Meeting the eligibility to qualify as a domestic partner;
3. The birth or adoption of a child;
4. The loss of coverage eligibility for a dependent child who, for example, becomes ineligible due to age or recovery from a disability;
5. The loss of coverage under your spouse's (same or opposite sex)/civil union partner's/domestic partner's or other employer's plan;
6. The death of a spouse (same or opposite sex)/civil union partner/domestic partner or dependent child;
7. The issuance of a Qualified Medical Child Support Order (QMCSO);
8. Relocation outside your medical and/or Cigna Dental HMO's network area;
9. The start of a military leave of absence;
10. The loss of group Basic Life insurance;
    - If your total compensation for benefits purposes increases such that you become ineligible for Basic Life/AD&D, this loss of coverage constitutes a qualified change in status for enrollment in GUL/Supplemental AD&D insurance. If you have not previously elected the maximum coverage under GUL, during annual enrollment you can elect GUL equal to one times your total compensation, not to exceed $500,000, without providing evidence of good health.
11. The loss of Medicaid or Children's Health Insurance Program (CHIP) coverage; and
12. The start of eligibility for state premium assistance.

If you are eligible for health coverage from Citi, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are not enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or call 1-877-KIDS NOW or visit **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plan, as long as you and your dependents are eligible but not already enrolled in the Plan. This is called a "special enrollment" opportunity, and you must call the Citi Benefits Center and ask to enroll within 60 days of being determined eligible for premium assistance.

The following is a list of qualified changes in status that will allow you to change 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 another 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 or recovery from disability;
- **Residence**: A change in the place of residence for you, your spouse, or another dependent if outside your medical or Cigna Dental HMO's network 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 (same or opposite sex)/civil union partner/domestic partner 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 current 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 (same or opposite sex)/civil union partner/domestic 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 the Citi Benefits Center within 31 days to make a change as a result 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 (same or opposite sex)/civil union partner/domestic partner, 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/same sex spouse: The events qualifying you to make a midyear election change described in this section also apply to events related to a civil union partner/domestic partner/same sex spouse. 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/same sex spouse, generally that change must be made on an after-tax basis, unless your civil union partner/domestic partner/same sex spouse can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your civil union partner/domestic partner/same sex spouse 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: If you or your dependents become eligible for premium assistance or lose eligibility for Medicaid or a state's Children's Health Insurance Program (CHIP), you have special enrollment rights under the Plan. You must contact the Citi Benefits Center to request to enroll in coverage under the medical Plans within 60 days of the noted occurrence.

Medicaid and the Children's Health Insurance Program (CHIP) offer free or low-cost health coverage to children and families

If you are eligible for health coverage from Citi, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are *not* enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or call 1-877-KIDS NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plan, as long as you and your dependents are eligible but not already enrolled in the Plan.

How to report a qualified change in status event

You have 31 days from the date of the event (60 days in the event of the loss of Medicaid and CHIP coverage, and the start of eligibility for state premium assistance) to report a qualified change in status event and, if applicable, to change 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. When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for

coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

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. You will be subject to any changes in costs associated with the changes in coverage category.

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

- Call the Citi Benefits Center via 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** and click on "Health and welfare benefits."
- To enroll in Group Universal Life (GUL) insurance, call MetLife at **1-800-523-2894**.

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 (or, where applicable, 60 days) of the qualified event; otherwise, 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 your "Health care plans offered by Citi" for details.) However, if you have coverage under any of the Plans, you must report this qualified 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 qualifying 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 will not be covered. New dependent coverage is subject to dependent verification.

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. However, you must provide evidence of good health except when enrolling as a new hire, when your total compensation increases to $50,001 or above (you will be enrolled automatically and the applicable contributions will be deducted from your pay unless you decline 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 Disability 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 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 and 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 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.

Once enrolled in GUL, you will automatically receive Supplemental AD&D coverage in the same amount as your GUL coverage. Cigna administers the Supplemental AD&D coverage 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. Coverage will begin on the first day of the month after you or your dependent's application is approved. You must be actively at work for coverage to be effective. Your eligible dependents must not be disabled on the date their coverage is to become effective. The John Hancock Life Insurance Company (U.S.A.,) which insures the benefit, will require evidence of good health before coverage is approved.

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, or you otherwise cease to be eligible for coverage;
- The day you die;
- To the extent applicable, the date benefits paid on your behalf equal the lifetime maximum benefit under the Plan for such category of benefits;
- Midnight of the last day of employment if your termination is due to gross misconduct; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

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 end on the last day of the month in which your employment is terminated. See the 'Long-Term Care insurance' subsection of the 'Insurance' section for more information.

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 if covered survivors elect COBRA;
- The date you elect to end your eligible dependent's coverage;
- The date you become legally separated, divorced, submit a domestic partnership termination form, or submit other legal documents showing your termination of the relationship to your spouse (same or opposite sex)/civil union partner/domestic partner;
- 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 (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age);
- 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;
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order;
- The date defined in the dependent verification package if proof of eligibility is not received by the deadline; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 36.

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

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 if a COBRA election is made, until the end of the calendar year, if the calendar year extends beyond the initial 13 weeks of coverage.

If you are totally disabled, coverage will continue as follows:

Medical: Coverage will continue for 52 weeks, including the 13-week period of Short-Term Disability (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 Long-Term Disability [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). For the purposes of the Plan, a year of service is any twelve (12) consecutive months in which you have provided 1,000 hours of service.

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 and have not received the maximum LTD benefit available under the Plan

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 to determine your eligibility to continue in applicable health and welfare benefits at the active rate. 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, the disability administrator will medically manage your claim.

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 or if earlier, you become eligible for Medicare because you attained age 65, 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 Savings Account (HSA): Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may choose to make additional contributions, on an after-tax basis, directly to your HSA by contacting ConnectYourCare. Any remaining balance is yours to take with you when you leave Citi.

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. If your employment is terminated, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit any balance in your account.

Coverage for surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependents

When an active employee dies, the surviving spouse (same or opposite sex)/civil union partner/domestic partner 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

The Citi Benefits Center will send your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children a COBRA notification package. For your surviving spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children 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 within the election period. See "COBRA" beginning on page 36.

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.

If the surviving spouse was not enrolled in active employee coverage at the time of the employee's death, he or she is eligible for retiree health coverage but not COBRA coverage.

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 (same or opposite sex)/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 a different leave period.

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 spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children and continue participating in the HCSA or LPSA 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 for them and failure to pay the billed amount will result in a loss of coverage.

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 may also 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 36 regarding continuation of coverage.

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 for them and failure to pay the billed amount will result in a loss of coverage. 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 - Citi policy

The Citigroup Paid Military Leave of Absence Policy is updated from time to time. For the latest copy of the policy, visit **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, you are entitled to receive a taxable distribution of your HCSA or LPSA 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 (USSERA), as long as you give Citi notice of your leave as soon as practical (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 a 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 Department of Labor regulations.

If you are on a 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, their spouses (same or opposite sex)/civil union partners/domestic partners 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 (same or opposite sex)/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 (same or opposite sex)/civil union partner's/domestic partner'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 (same or opposite sex)/civil union partner/domestic partner;
2. The termination of your spouse's (same or opposite sex)/civil union partner's/domestic partner's employment (for reasons other than your spouse's (same or opposite sex)/civil union partner's/domestic partner's gross misconduct) or a reduction in your spouse's (same or opposite sex)/civil union partner's/domestic partner's hours of employment;
3. Divorce or legal separation from your spouse (same or opposite sex) or the termination of your civil union partnership/domestic partnership; or
4. Your spouse's (same or opposite sex)/civil union partner's/domestic partner'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 are also 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 is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification 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 provided 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 (same or opposite sex)/civil union partner/domestic partner 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 (same or opposite sex)/civil union partner/domestic partner 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, within 18 months after becoming entitled to Medicare, you subsequently lose coverage (medical, dental, vision, or HCSA or LPSA) 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' early termination of COBRA coverage will not extend beyond 36 months.

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.

The Health Insurance Portability and Accountability Act (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 (or otherwise under applicable law), the Plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualifies 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 spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent child is covered by the Plan on the day before the leave begins (or you or your spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent child) 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 period 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 period 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. You and your family members will be subject to these changes in the cost of coverage.

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

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator at the address 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 Citi-sponsored group health Plan should be directed to:

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

You may also 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 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. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the other sections of this Benefits Handbook.

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:** The Citi Plan will pay the difference, if any, between what you would have received from Citi if it were the only coverage and what you are eligible to receive from the other plan. Total benefits will never equal more than what the Citi Plan would have paid alone. 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, if they are not covered by another plan through their employment or through military service.

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 you are covered under the Citi Plan as an active employee, 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 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.

If you or your dependent are eligible for Medicare, and you are no longer an active employee, enrollment in Medicare cannot be deferred based on enrollment in COBRA.

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

Claims must be submitted in order to receive reimbursement for charges incurred under the Plans. Many times, the claim is submitted electronically to the claims administrator without your intervention needed. However, you may be required to manually submit a claim for expenses to be paid or approved for reimbursement. Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" in the Administrative Information section. 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 at **www.benefitsbookonline.com**, available from the Citi intranet and the Internet. No password is required.

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 **Citi For You** (intranet only) Or Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** and click on "Health and welfare benefits." You can also go directly to **http://resources.hewitt.com/citigroup**.
Empire BlueCross BlueShield ChoicePlan 500 High Deductible Health Plan – Basic and Premier	Health Insurance Claim Form for the plans administrated by Empire BlueCross BlueShield (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.	
HMOs	Call your HMO for any claim-filing information.	
Express Scripts (Prescription drug coverage for ChoicePlan 500, High Deductible Health Plan-Basic and Premier, and Hawaii Health Plan)	Express Scripts Prescription Drug Claim (Form 310) Use the form to file a claim for 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**.
Medco (Prescription drug coverage for Oxford PPO)	Form 320 — Medco by Mail Order Form (Form 320).	Call Medco at **1-800-905-0201** or visit **http://www.medcohealth.com**
MetLife Dental	MetLife Dental Claim Form (Form 304) Use the form to file a claim for covered dental expenses.	
Cigna DHMO	There are no claim forms required with the Cigna Dental HMO plan. When your Patient Charge Schedule lists a copay, pay that amount to the dentist directly after you receive care.	
Vision Plan	Vision Claim Submission Form to be reimbursed for covered out-of-network expenses.	Visit **www.aetnavision.com**.
Health Care Spending Account (HCSA)	If you do not use the Your Spending Accounts™ Card, you can file a claim using the HCSA/LPSA Reimbursement Request Form (Form 316). Use the form to submit eligible health care claims for reimbursement.	Visit **Citi For You** (intranet only) Or Visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com** and click on "Spending accounts." You can also go directly to **http://resources.hewitt.com/citigroup.**
Limited Purpose Health Care Spending Account (LPSA)	HCSA/LPSA Reimbursement Request Form (Form 316) Use the form to submit eligible vision, dental, and/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)	Not applicable **Note:** With the exception of the Parking Cash Reimbursement Option (CRO). CRO claims must be filed within 12 months from the date of service.	

Eligibility and participation

All claims for benefits must be filed by these deadlines:

- 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.
- TRIP claims must be filed within 12 months from the date of service.