Vision

The Vision Plan, administered by Davis Vision, offers a variety of routine vision care services and supplies. You do not have to be enrolled in the Plan to cover a dependent.

When you enroll in the Plan, it is on an annual basis. You can change your election only if you have a qualified status change, as described in the *Eligibility and Participation* section. When you enroll in the Plan, you will receive an ID card in the mail.

Both network and out-of-network benefits are available. You can split your benefit by going to both network and out-of-network providers. For example, you can obtain an annual eye examination from a Davis Vision provider while purchasing your frames and lenses out of network. However, before taking a prescription from one vendor to be filled at another vendor, you should confirm that the prescription will be honored.

Contents

Benefits at a Glance 129

Network Services 130

Using network services 130

Network benefits 130

Mail order contact lenses: Lens 1-2-3® option 131

Out-of-network benefits 131

Definition of medical necessity 131

Low vision 131

Laser vision correction 131

What is not covered 132

Splitting of benefits 132

Travel and student coverage 132

Claims and appeals for the Vision Benefit Plan . 132

Benefits at a Glance

The following table summarizes the vision benefits available to you and your eligible dependents:

Network benefit	Coverage
Eye exam	• Covered at 100% including dilation, one exam per calendar year.
Frames and lenses	• Covered at 100%, one pair of frames and lenses per calendar year. • Must be selected from the network-provided frames from Davis Vision's Exclusive "Collection"; or • $61 wholesale allowance toward retail frame purchases outside of the "Collection" or an equivalent retail allowance at a retail chain (e.g. Wal-Mart, Eye-Masters, VisionWorks, etc.) • 20% discount on additional pairs of glasses at most network providers.
Contact lenses (in lieu of glasses)	• Covered at 100%, limit 1 pair/supply per calendar year in lieu of eyeglasses; • Davis Vision Contact Lens "Collection"; one pair of soft, standard daily wear contact lenses; or • Davis Vision Contact Lens "Collection" covered; 4 boxes of disposable lenses; or • Davis Vision Contact Lens "Collection"; 2 boxes of planned replacement lenses; or • A $130 credit toward "Collection" contacts, fitting, and follow-up, plus 15% off overages; or • Medically necessary contact lenses covered in full with prior approval. The Plan covers a supply that is prescribed at the time of office visit.
Laser vision correction (Lasik)	• Up to 25% discount off reasonable and customary fees, or 5% discount off any advertised (discounted) fee when using one of Davis Vision's participating laser surgeons. Some centers have flat fees equivalent to these discounts.
Broken eyewear (frames, materials)	• Davis Vision "Collection" frames are covered by a one-year breakage warranty.
Maximum benefit	• Benefit that has been paid in full except for defined copayments.

Out-of-network benefit	Coverage
Eye exam	• Up to $30
Frames/lenses	• Frame; up to $50 • Single vision lenses up to $25, bifocal up to $35, trifocal up to $45, and lenticular up to $60
Contact lenses	• Contact lenses; up to $75 • Medically necessary contact lenses; up to $225

Network Services

To receive the greatest value for your dollar, you should receive vision care services from a Davis Vision network provider. However, you can also use out-of-network providers and still receive a benefit.

Network providers are licensed doctors in your area who provide quality vision care services and who meet Davis Vision's quality assurance standards. You and your covered family members can select a different Davis Vision network provider each time you receive vision care services.

Your doctor may apply to join the Davis Vision provider network by calling Davis Vision's Professional Relations Department at 1-800-933-9371. Membership in the network is not guaranteed.

Using network services

Davis Vision network services are easy to access. Below is the information you will need to find a network provider in your area and schedule an appointment.

- To locate a network provider, visit Davis Vision at **www.davisvision.com** or call 1-800-999-5431. If you are enrolled in the program, enter the employee's Member Identification number. If you are not enrolled in the program or are going through annual enrollment, you can access the open enrollment feature through the Davis Vision website (**www.davisvision.com**) and enter Client Control Code number 2227. You may also call Davis Vision during your enrollment period at 1-877-92-DAVIS. (For TDD services, call 1-800-523-2847.) An automated voice response unit (available 24/7) or one of Davis Vision's member service representatives (available from 8 a.m. to 11 p.m. on weekdays; 9 a.m. to 4 p.m. on Saturdays; and noon to 4 p.m. Eastern time on Sundays) will assist you. Once you are enrolled, you can call Davis Vision at 1-800-999-5431 to verify your eligibility.
- Call a network provider to schedule an appointment. Claim forms are not required.
- Provide the doctor with the Citi employee's member ID number. If you are calling for services for your covered dependent, you will need to provide your dependent's date of birth.
- A complete list of network providers is available at no cost to you by calling Davis Vision at 1-800-999-5431 or visiting Davis Vision at **www.davisvision.com**.

The network provider will obtain the necessary authorization. After the provider obtains authorization, you and/or your dependent(s) will have up to 45 days to receive your eye exam from that provider.

If you decide to use a different provider after the previous provider has received an authorization and you have made an appointment, you must call Davis Vision at 1-800-999-5431. You are responsible for canceling your appointment and any related cancellation fees.

Network benefits

Network benefits include:

- Exam: one eye examination, including dilation, when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: one pair of eyeglasses each calendar year from the Davis Vision "Collection" covered at 100%; or
- A $61 wholesale allowance toward the cost of any network provider's frame or an equivalent retail allowance at a retail chain, for example, a $150 allowance at a Wal-Mart location; spectacle lenses will be covered at 100%; or
- Contact lenses in lieu of eyeglasses: plan formulary contact lenses; one pair of soft standard daily-wear or four boxes of disposable or two boxes of planned replacement contact lenses, fitting, and follow-up care each calendar year covered at 100%, or, if you choose contact lenses that are not covered under the Plan formulary, you will receive a maximum credit of $130 toward other lenses plus 15% off the amount above $130 (additional discount not applicable at Wal-Mart locations); the $130 credit is applied toward non-plan contacts, fitting, and follow-up.
- 20% discount on additional pairs of glasses at most network providers.

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

Mail order contact lenses: Lens 1-2-3® option

You can purchase replacement or additional pairs of contact lenses by mail through the Lens 1-2-3® program, a Davis Vision program. Call 1-800-LENS-123 (1-800-536-7123) for answers to your questions or to place an order. To receive lenses through Lens 1-2-3®, mail your current prescription to:

Lens 1-2-3®
2921 Erie Boulevard East
Syracuse, NY 13224.

You can also fax your prescription to 1-315-449-0563.

If you do not have a copy of your prescription, a Lens 1-2-3® representative can contact your provider directly.

Out-of-network benefits

If you receive services outside the Davis Vision provider network, the Plan will provide reimbursements of up to the following amounts:

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

Definition of medical necessity

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

Contact lenses may be determined to be medically necessary in the treatment of keratoconus, anisometropia corneal disorders, pathological myopia, aniseikonia post-traumatic disorders, aphakia, aniridia, and irregular astigmatism. Davis Vision must review and approve any coverage for medically necessary contact lenses.

Low vision

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

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

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

Laser vision correction

Laser vision correction is not covered under the Plan. However, a discount is available if you use a provider in the Davis Vision laser vision correction network. You are eligible for up to a 25% discount off the provider's reasonable and customary fees or a 5% discount off any advertised fee for laser vision correction surgery at a Davis Vision provider.

Some facilities may offer a flat rate, which equates to these discount levels. You are responsible for paying all fees directly to the provider or facility. *Davis Vision and Citi assume no financial responsibility for access to these discounts in your location.*

The list of doctors and facilities performing laser vision correction is different from the routine vision provider listing. For more information about laser vision correction, call Davis Vision at 1-877-923-2847 or visit **www.davisvision.com**. Enter Citi code 2227 for a list of participating providers.

What is not covered

The following services and materials are not covered under the Plan:

- Medical treatment of eye disease or injury;
- Vision therapy;
- Special lens designs or coatings (other than those previously described);
- Replacement of lost eyewear;
- Two pairs of eyeglasses in lieu of bifocals;
- Services or materials covered under Workers' Compensation;
- Eye exams required as a condition of employment;
- Non-prescription eyewear or lenses;
- Contact lenses and eyeglasses in the same benefit cycle; and
- Services not performed by licensed personnel.

Note: You may purchase glasses from a network provider and order contact lenses through Lens 1-2-3® in the same 12-month benefit cycle. You will have to pay the out-of-pocket costs for the contact lenses; but the prices generally are discounted approximately 50%.

Splitting of benefits

To maintain continuity of care, whenever possible you should obtain all available services at one time from either a network or an out-of-network provider. However, you may "split" the benefit by receiving services from both network and out-of-network providers.

Travel and student coverage

If you or your covered dependent(s) require vision care services while traveling or away at school, visit Davis Vision at **www.davisvision.com** or call Davis Vision at 1-800-999-5431 and enter the employee's member ID number.

Claims and appeals for the Vision Benefit Plan

The amount of time Davis Vision will take to make a decision on a claim will depend on the type of claim.

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period) Notice that more information is needed must be given within 30 days You have 45 days to submit any additional information needed to process the claim*
Preservice claims (for services requiring precertification of services)	Decision within 15 days; one 15-day extension (notice of the need for an extension must be given before the end of the 15-day period) Notice that more information is needed must be given within five days You have 45 days to submit any additional information needed to process the claim*
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Decision made within 72 hours Notice that more information is needed must be given within 24 hours You have 48 hours to submit any additional information needed to process the claim; you will be notified of the decision within 48 hours of receipt of the additional information
Concurrent care claims (for ongoing treatment)	Decision made within 24 hours for urgent care treatment Decision made sufficiently in advance for all other claims

* Time period allowed to make a decision is suspended pending receipt of additional information.

You will have 180 days following receipt of a claim denial to appeal the decision. You have the right to voice a grievance or complaint against Davis Vision at any time. Davis Vision will not retaliate or take any discriminatory action against you because you have filed a grievance, complaint or appeal. A grievance is a complaint that may or may not require specific corrective action and is made:

- Via the telephone;
- In writing to Davis Vision; or
- Via the Davis Vision website.

Claims include, but are not limited to, the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;
- Difficulty accessing or using a benefit and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, "adverse determination."

You may file a grievance by

- Calling Davis Vision's toll free hot line 24 hours a day at 1-800-584-1487;
- Sending a letter via U.S. mail or overnight delivery; or
- Visiting the website at **www.davisvision.com**.

Written grievances should be sent to:

Davis Vision
159 Express Street
Plainview, NY 11803
Attention: Quality Assurance/Patient Advocate Department

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

You will be contacted by a Davis Vision associate within five business days of receipt of a concern or grievance to confirm that the concern was received and is being investigated. A designated Davis Vision associate will review the appeal with you and may request additional information. You will be provided with the associate's name, phone number, department, and the estimated time needed to perform the research (for preservice appeals, 15 days; for post-service appeals, 30 days) and when you can expect a determination. You will also be informed of your right to have a representative, including your provider, present during the review of the concern and final outcome of the investigation. You also will be informed of your right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

When grievances pertain to clinical decisions, the review committee will include a licensed (peer) health care professional. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point-of-service location to determine the root cause of the concern. When warranted the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. When further information is required, Davis Vision will contact you and inform you of the status of the investigation and/or the need for more information.

At the conclusion of the investigation, the determination will be communicated within 15 days for preservice claims and 30 days for post-service claims, or as required by state statute, (or an additional 10 days may be requested to complete further research). The appeal determination will include the following:

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were used and a summary of the evidence, including the documentation supporting the decision;
- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;
- Copy of the appeals process, if applicable; and
- Name, position, phone number, and department of the person(s) who was responsible for the outcome.

The decision of the Quality Assurance/Patient Advocate Department is final and binding unless you appeal to Davis Vision within 15 business days of the date of notice of the decision.

Davis Vision level two appeal

Should Davis Vision uphold a denial, as the result of a level one review, you have the right to request a level two appeal.

A level two appeal will not include any associate(s) or licensed (peer) health care professional(s) who was involved in the level one review.

A level two appeal requires you to contact Davis Vision in writing or by telephone within 15 days following your receipt of the level one summary statement.

If you are requesting a level two appeal, you must indicate the reason you believe the denial of coverage/benefit was incorrect. Davis Vision reserves the right to solicit further information from you and/or the provider.

Davis Vision has 30 days, or as required by state statute, from the date the requested information is received, to respond to the level two review, or 45 days, or as required by state statute, if it is a post-service review. A level one decision will be reviewed by a Davis Vision associate(s), a Regional Quality Assurance Representative(s) (RQAR), and a licensed optometrist, all of whom were not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within five days.

Notification will include, but may not be limited to:

- The outcome of the investigation and a summary stating the nature of the concern and the material facts related to the issue;
- Criteria that were used and a summary of the evidence, including documentation that was used to support the decision;
- A statement indicating that the decision will be final and binding unless you appeal in writing or by telephone to the Quality Assurance/Patient Advocacy Department within 45 days of the date of the notice of the level two decision;
- A copy of the appeals process, if applicable; and
- The name, position, phone number, and department of person(s) who was responsible for the outcome.

External review

Davis Vision gives you, as required by state statute, an opportunity to request an impartial review of concerns that resulted in coverage denials. If you have used and exhausted the internal appeals process, you may appeal the final decision if the denial for services exceeds $250 and was not deemed medically necessary or the requested service was deemed investigational or experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organization will have up to 30 days, or as required by state statute, to make a determination.

Davis Vision, a national provider of vision care benefits, recognizes that each state has implemented an external review process that is unique to its residents. Individual states have mandated the use of their own external review process for appeals based on medical necessity. You can call the Member Service Department at 1 800 999 5431 for information unique to your state of residence. You also have the right to contact your state insurance or health department for further information.

You have the right to an external review of a denial of coverage. You have the right to an external review of a final adverse decision under the following circumstances:

- You have been denied a vision care service, which should have been covered under the terms of the Vision Plan;
- Services were denied on appeal on the basis that requested services were not medically necessary;
- A treatment or service that will have a significant positive impact on you has been denied and any alternative service or treatment will not affect your ocular health and/or will produce a negative outcome;
- The services denied are related to a current illness or injury;
- The cost of the requested services will not exceed that of any equally effective treatment;
- The denied service, procedure, or treatment is a covered benefit under the Vision Plan; or
- You have exhausted all internal appeal processes with an adverse determination upheld at each level.

The vision care provider may contact the appropriate state agency to determine if other documentation may be required for the appeal process.

The external review representative must make a decision within 30 days of receipt of documentation, or as required by state statute, and notify you within two business days of a determination. Notification must be in writing and include an explanation and the clinical criteria used in the decision.

Wellness benefits

Your Citi benefits include programs intended to help you improve your health and reduce health care costs. These programs include:

- The Citi Live Well Program;
- Citi on-site medical clinics; and
- Citi on-site health and fitness centers.

Contents

The Citi Live Well Program 135

Health Advocate 136

Health Assessment 136

Personal Health Record 137

Live Well Health Management Program 137

24-Hour Nurseline 138

Lifestyle Management Tools 138

Important information about the Citi Live Well Program 138

Citi on-site medical clinics 138

Citi on-site Health and Fitness Centers 139

The Citi Live Well Program

The Citi Live Well Program is designed to help you improve your health. Live Well gives you and your family the tools and resources to both manage your health care and achieve your health goals. Here are the components of the Live Well Program.

CITI LIVE WELL PROGRAM AT A GLANCE

Live Well tools and resources	Description	Who participates	How to access
Health Advocate	A free, personal support service to help you manage your health care needs, from working through difficult health claims to choosing a doctor to making choices regarding a serious illness.	Active employees (full time and part time), their spouses (whether same or opposite sex)/partners, dependents, parents, and parents-in-law. You do not need to be enrolled in a medical plan offered by Citi to use Health Advocate.	1-866-449-9933 from 8 a.m. to 9 p.m. ET on weekdays; after hours and on weekends, leave a message and a representative will return your call the next business day.
Health Assessment on the Citi Live Well Portal	A secure, online health questionnaire that is a part of your Personal Health Record. By completing it, you can learn more about your health.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical plan offered by Citi. However, spouses/partners must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/partner can go to **www.activehealthportal.net/citi**.
Personal Health Record on the Citi Live Well Portal	A secure, online health record to keep track of important health information in one place.	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical plan offered by Citi. However, spouses/partners must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/partner and dependents 18 and over can go to **www.activehealthportal.net/citi**.

Wellness benefits

CITI LIVE WELL PROGRAM AT A GLANCE			
Live Well tools and resources	Description	Who participates	How to access
Live Well Health Management Program	Programs to help you improve and manage your health.	Active employees, their spouses/partners, and dependents who are enrolled in one of the following medical plans offered by Citi and are invited by ActiveHealth to participate: Aetna, Empire BlueCross BlueShield, and Oxford Health Plans.	1-800-490-3054 More information on the program may be found on the Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/civil union partner/domestic partner and dependents 18 and over can go to **www.activehealthportal.net/citi**.
24-Hour Nurseline	Access to nurses who can respond around the clock to immediate health issues.	Active, benefits-eligible employees, their spouses/partners, and dependents. You do not need to be enrolled in a medical plan offered by Citi to call the 24-Hour Nurseline.	1-866-494-7879; available 24/7
Lifestyle Management Tools	Tools and trackers that can support lifestyle changes such as exercising, healthy eating, and quitting tobacco	Active, benefits-eligible employees can participate and do not need to be enrolled in a medical Plan offered by Citi. However, spouses/partners and dependents must be enrolled in a medical plan offered by Citi to participate.	Citi Live Well Portal via Total Comp @ Citi at **www.totalcomponline.com**; your spouse/civil union partner/domestic partner and dependents 18 and over can go to **www.activehealthportal.net/citi**. From the Personal Health Record website, click on "Active Lifestyle Coaching."

Health Advocate

Health Advocate is a free program available to you *and* your family (spouse (whether same or opposite sex)/civil union partner/domestic partner, children, parents, and parents-in-law), regardless of your health coverage. You and your family members do not need to be enrolled or eligible to participate in a medical Plan offered by Citi to use Health Advocate.

Health Advocate helps you take control of your health care issues. You and your family can call Health Advocate to speak with a staff of medical professionals and health-related specialists to help you:

- Resolve insurance claims and billing issues;
- Identify and make appointments with a hard-to-reach specialist;
- Obtain additional information about a medical condition;
- Address medical issues and health care needs of your family members; and
- Understand issues related to prescription drugs, such as comparisons between generic and brand-name medications.

Health Assessment

The Health Assessment is a brief, online questionnaire that provides a snapshot of your current health status and may recommend ways to make healthy changes. It can help you build your Personal Health Record.

The Health Assessment is available to active, benefits-eligible employees. You do not need to be enrolled in a medical plan offered by Citi to participate. Spouses (whether same or opposite sex)/civil union partners/domestic partners may also complete the Health Assessment but only if they are enrolled in a medical plan offered by Citi.

The Health Assessment is a simple, secure, online questionnaire that takes about 15 minutes to complete. It immediately generates a personalized report summarizing your health. You can use the report to discuss concerns with your doctor, as a checklist of questions to ask, or to update your doctor on your health status, for example, if any signs or symptoms are worsening. If you have previously taken the Health Assessment, you are able to update your prior responses and answer new questions at any time. It is linked automatically to your Personal Health Record, described below.

An alert will be sent to you and your doctor if your Health Assessment report indicates an opportunity to improve your care. You also may receive an outreach call from a nurse, if applicable.

Personal Health Record

The Personal Health Record gives you a place to store all of your medical information. Depending on the medical plan in which you are enrolled, it can provide:

- A health summary of your conditions, allergies, prescribed medications, and recent testing, based on the claims submitted by your providers to your medical plan;
- Ways to help you track your hospital visits and insurance claims information;
- Personalized alerts that notify you of health risks, such as for high blood pressure, or health reminders to get an annual screening; and
- Online health information resources, including a medical dictionary, to put information at your fingertips whenever you need it.

Even if you are not enrolled in an Aetna, Empire BlueCross BlueShield, or Oxford Health Plans, the Personal Health Record can still help you track activities to manage your health. You can keep your Personal Health Record up to date by entering recent doctor's visits, immunizations, medications, and other information.

If you, your spouse (same or opposite sex)/civil union partner/domestic partner, and dependents are enrolled in one of the Plans listed above, your Personal Health Record and that of your family will be populated automatically with the pertinent claims data from your health care provider.

To opt out of the Personal Health Record, you must call 1-800-490-3054 to terminate your access to the database.

Live Well Health Management Program

The Live Well Health Management Program offers support, tools, resources, and information about your health to help you and your doctor better manage your care.

Depending on your health history, claims data, and information entered into your Health Assessment and Personal Health Record, you may be invited to participate in the Live Well Health Management Program.

You may benefit from the Live Well Health Management Program in two ways:

1. Care Considerations and
2. Nurse coaching support for covered conditions (by invitation only).

Care Considerations

A Care Consideration is an alert, based on your medical claims and other medical information, sent to you and your doctor from ActiveHealth, a third-party hired by Citi. These Care Considerations identify an opportunity to improve your health care. Care Considerations provide information that could affect your health, may require action by you and/or your doctor, and are designed to promote care according to medical best practices and to identify potential medical issues.

Nurse coaching support for a covered condition

Covered conditions include asthma; arthritis; cancer; chronic low back pain; cystic fibrosis; gastrointestinal conditions, such as Crohn's disease; migraines; renal disease; sickle cell disease; vascular conditions, including diabetes, coronary artery disease, high blood pressure, and high cholesterol; and weight management (obesity).

As part of the Live Well Health Management Program, you will receive support including educational materials, information about warning signs, and suggestions for questions and issues to discuss with your doctor. The program does not replace your doctor; rather, it is designed to enhance your care and help you and your doctor make more informed decisions about your health.

This program is voluntary. If you are invited to participate but decide that you do not want to participate, call the Citi Live Well Program at 1-800-490-3054 and notify a nurse that you want to be removed from the program. You can rejoin the program at any time by calling the same number.

During 2010, Citi is offering a new program called Live Well Rewards. If you complete four telephone sessions with a nurse during 2010, you will receive a $150 credit toward the cost of your annual medical, dental, or vision coverage. Any excess credits will be put into a Health Care Spending Account or Limited Purpose Health Care Spending Account. ActiveHealth will notify the benefits administrator quarterly that you have completed your fourth telephone session with a nurse and the annual credit will be applied for the remaining pay periods of 2010. Employees as well as spouse/partners who are covered under a medical Plan offered by Citi are eligible to earn the Live Well Rewards.

24-Hour Nurseline

The 24-Hour Nurseline is available 24/7 to active, benefits-eligible employees and their spouses/civil union partners/domestic partners and dependents. You can call the 24-Hour Nurseline at any time to speak with a registered nurse who can answer questions about an immediate health issue or any other health topic.

The 24-Hour Nurseline can help when you or your family members experience medical symptoms or have a health question, such as:

- "My child is running a fever";
- "I think I have poison ivy"; or
- "I have a pain in my arm."

You also have 24-hour access to an audio health library equipped with information on more than 2,000 health topics and accessible on demand through any touch-tone in both English and Spanish. For a list of topics, visit the Citi Live Well Portal at **www.activehealthportal.net/citi** and, from the top of the page, click on "24-Hour Nurseline."

Call 1-866-494-7879 to access the 24-Hour Nurseline and audio health library.

Lifestyle Management Tools

Available via the Citi Live Well Portal, these tools and trackers can support lifestyle changes such as exercising, healthy eating, and quitting tobacco.

There is no cost to you to use these or any of the Live Well resources. The tools can help you take charge of your health and potentially change certain behaviors. Because the tools are online, you can take advantage of them on your own schedule and at your own pace. To make these tools work even better for you, if you have not done so already, be sure to complete the Health Assessment on the PHR website. To access the online tools, log in to the PHR website and click on the "Active Lifestyle Coaching" link.

Employees can visit the Personal Health Record (PHR) via Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. Spouses and domestic partners can go to **www.activehealthportal.net/citi.** Then, click "Personal Health Record" and follow the links.

Since the tools are available through the PHR website, the access for the tools is the same as that noted for the PHR above.

Important information about the Citi Live Well Program

The Citi Live Well Program was designed to provide for your privacy and to comply with all federal and state privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Personal health information is maintained by a third-party vendor (ActiveHealth, a subsidiary of Aetna) and is not maintained on Citi data systems.

All information provided through the Citi Live Well Program is available for review by you, your doctors, and other health care professionals. Safeguards have been implemented to prevent your personal information from being seen by or shared by other persons. No Citi employee should see your health information on the Personal Health Record website. Citi will receive aggregate reports to review the performance of the program.

By enrolling in the Citigroup Health Benefit Plan, you consent to the terms and conditions of the Citi Live Well Program, as they may be amended from time to time. If you are enrolled in Aetna, Empire BlueCross BlueShield, or the Oxford Plan, your claims information, including prescription drug information, will be transmitted to ActiveHealth (described above) as part of your participation in the Citigroup Health Benefit Plan.

Note: The Personal Health Record may not contain all of the information about your health, unless you supply such information. Alerts or Care Considerations may be mailed to your home if opportunities to improve your health are indicated.

Citi on-site medical clinics

Citi operates medical clinics at the following locations: Jacksonville and Tampa, FL; Warren, NJ; 399 Park Ave., 111 Wall St., and 388 Greenwich St., New York, NY; Long Island City, NY; and San Antonio, TX.

The clinics offer the following services:

- Assessment, treatment, recommendations, and/or referral for illness and injury;
- Laboratory blood tests, and EKGs on the order of the employee's physician;
- Ergonomic workstation evaluations;

- Lactation rooms including: pumps, refrigerator for milk storage, and attachment kits for purchase;
- Immunizations and consultations for international business travel;
- Periodic medical exams for expatriate staff and spouses;
- Referrals to appropriate medical specialists and other on-ground resources worldwide for expatriate staff and international business travelers; and
- Monitoring of international medical care and emergency medical evacuations coordinated through **Travel Health Services** and Citi Travel Health Assistance.

Citi on-site Health and Fitness Centers

All Citi Health and Fitness Centers (HFCs) are staffed by degreed fitness professionals who work closely with employees to create customized exercise programs and work together to plan and achieve individual goal targets. All employees in locations with on-site HFCs who desire membership must complete a health and entry screening process that includes two short appointments during which medical history, program policy, safety, goals, and equipment operations are reviewed.

Members are then provided with information and recommendations about frequency, duration, mode, and intensity of an individualized exercise program. Fitness center staff members are available and ready to assist with program updates and changes throughout your visits to the Citi facilities.

All Citi fitness facilities feature strength and cardiovascular equipment, and most offer a variety of group exercise classes at no additional charge.

HFCs frequently offer motivational or incentive programs; screenings, such as cholesterol, blood pressure, and skin cancer; and site-wide events to educate and motivate employees toward healthy lifestyle changes and maintenance.

Most of the HFCs offer towel service at no additional charge, and some offer other services, such as massage therapy, nutrition programming, and/or personal training for a fee.

The HFCs have a fee structure that is very competitive for the surrounding geographic area and typically is well below market rates for similar operations and facilities. Visit your HFC for membership fee rates.

Citi operates HFCs at the following locations:

Albuquerque, NM; Getzville (Amherst), Long Island City, and New York, NY; Bayamon, PR; Blue Ash, OH; Meridian (Boise), ID; Elk Grove Village, IL; Florence and Louisville, KY; Mcleansville (Greensboro), NC; Hagerstown, MD; Irving and San Antonio, TX; Jacksonville and Tampa, FL; Kansas City, MO; Las Vegas, NV, Mississauga, Ontario; Sioux Falls, SD; and Warren, NJ. More information is available on the Citi intranet at **www.citigroup.net/human_resources/chs/.**

Wellness benefits

Employee Assistance Program (EAP)

The EAP is a confidential, professional counseling service designed to help you and your family resolve issues that affect your personal lives or interfere with job performance. You may call the EAP 24/7 for help with issues such as anxiety or depression, substance or alcohol abuse, emotional and physical abuse, domestic conflict, and other issues.

When you or an immediate family member calls the EAP, you will speak with a professional counselor who will listen to your concern and, if warranted, refer you to an appropriate counselor in your community. You can attend up to three in-person counseling sessions with a program counselor at no cost to you before your referral. If you require additional counseling, you will be responsible for any fees. Expenses for subsequent counseling may be covered by other Citi health plans.

All EAP services are completely confidential.

The EAP is a core benefit available to all benefits-eligible employees. You do not have to enroll or make any contributions to use this benefit. Citi provides an employee assistance program through a contract with Harris Rothenberg International, LLC.

Contact the EAP as follows:

1-800-952-1245
TTY: 1-800-256-1604
www.harrisrothenberg.com
Username: resources
Password: for_you

Employee Assistance Program (EAP)

LifeWorks Program

LifeWorks is designed to save you time and provide peace of mind. The confidential service is available 24/7 by telephone and on the Web. Whether you are researching options for child care, sending a son or daughter to college, or dealing with the needs of your elderly parent far away, the LifeWorks Program can help. *All LifeWorks services are completely confidential.*

Call LifeWorks for information and practical solutions; customized referrals; and resources and research information on a wide variety of topics ranging from parenting/child care to adoption, education, older adults, and work issues. You can also obtain assistance with everyday issues like locating a pet or house sitter, home remodeling and repair services, and purchasing and consumer issues.

The LifeWorks Elder Care Management Program

When an older relative's physical or mental health changes or her or his ability to handle day-to-day routine activities is impaired, the stress on you and your family can be significant. Few of us have the expertise to determine which concerns require immediate care. The situation can be more difficult for those who live at a distance from older relatives.

LifeWorks can provide the following:

- Legal consultations and discounts on attorney fees;
- In-person assessment of an older relative's situation and recommendations for services, products, or a change in residence;
- Scheduled check-in services — by telephone or in person — to monitor your relative's condition and care no matter where she or he lives in the United States;
- Professional assistance to manage the different services and health-related products your relative may be using or to arrange for necessary services;
- On-site facility reviews so you may compare and choose elder care facilities; and
- Respite care to provide time off for family caregivers.

Citi's Elder Care Management Services makes the LifeWorks program a more complete resource to help you care for the people who are important to you.

Contact the Citi LifeWorks Program as follows:

1-800-635-0606 (voice and TTY)
www.lifeworks.com

Username: resources
Password: for_you

Spending Accounts

Spending accounts allow you to pay for certain health care, dependent day care, and transportation expenses with pretax contributions from your pay.

- Health Care Spending Account (HCSA)**:** Use the HCSA to pay for certain health care expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan. You are eligible to enroll in the HCSA if you are not enrolled in a High Deductible Health Plan. *If you enroll in a High Deductible Health Plan, you cannot enroll in the HCSA.*

Your Spending Account™ Website

The Your Spending Account™ (YSA) website makes it easy for you to manage your spending accounts. You can file claims, confirm which expenses are eligible, check your account balance, and more! See the YSA Guide for more information.

- Limited Purpose Health Care Spending Account (LPSA)**:** Use the LPSA if you are enrolled in a High Deductible Health Plan-Basic or Premier and establish a Health Savings Account (HSA) to pay for dental, vision, and/or preventive care medical expenses for yourself and your qualified dependents that are not paid by any medical, dental, or vision plan or your HSA.
- Dependent Day Care Spending Account (DCSA)**:** Use the DCSA to pay for certain dependent day care expenses so that you (and your spouse, if you are married) can work or look for work. **Reminder:** This account cannot be used to pay health care expenses for your dependents.
- Transportation Reimbursement Incentive Program (TRIP)**:** Use the TRIP to pay for the cost of public transportation and parking so you can commute to work. **Note:** TRIP is not part of annual enrollment. You can enroll at any time.

Contents

How the spending accounts work 146

Enrolling in the spending accounts 146
Changing your contribution amounts 146
Legal requirement: Save your receipts 147
Reimbursements 147
Spending accounts at a glance 147

Health Care Spending Account (HCSA) 148

Rules and features 148
Health Care Spending Account Reimbursement Card .. 150
Automatic claims submission 150
Reimbursements 151
Using HCSA during an unpaid leave or after your termination of employment 151
Effect on other benefits 151
Effect on taxes 151
Social Security 151
Filing a claim 151
For more information 151

Limited Purpose Health Care Spending Account (LPSA) 151

Rules and features 151
Paying for your expenses out of pocket 153
Reimbursements 153
Using LPSA during an unpaid leave or after your termination of employment 153
Effect on other benefits 153
Effect on taxes 153
Social Security 153
Filing a claim 154
For more information 154

Dependent Day Care Spending Account (DCSA) 154

Rules and features 154
Qualifying individuals 155
Marital status and your DCSA contribution 155
Reimbursements 155
Effect on other Citi benefits 155
Effect of DCSA participation on Social Security 156
Using DCSA after your termination of employment 156

DCSA subsidy 156
Filing a claim 156
For more information 157

Transportation Reimbursement Incentive Program (TRIP) 157

How the program works 157
Changing your TRIP pass election 158
Tax exemptions 158
If your employment is terminated 158
Filing a claim 158
For more information 158

Claims and appeals for the HCSA/LPSA 159

How the spending accounts work

Enrolling in the spending accounts

To have continued coverage in the Health Care Spending Account, Limited Purpose Health Care Spending Account, and/or Dependent Day Care Spending Account, you *must* enroll each year. *Your election does not roll over from year to year.*

For TRIP, you can enroll at any time. Pretax, and if needed, after-tax, payroll contributions will be taken as soon as administratively possible to pay for your transit and/or parking pass, which must be purchased online.

Once enrolled, you can obtain information about your account on Your Benefits Resources™:

- Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
- Go directly to Your Benefits Resources™ at **http://resources.hewitt.com/citigroup**.

Contributions to the spending accounts from your pay will be available as follows:

If you enroll during the annual enrollment period:

- **HCSA and LPSA:** The entire amount of the 2010 contributions you elect will be posted to your account January 1.
- **DCSA:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.

If you enroll as a new hire:

- **HCSA and LPSA:** The entire amount of the 2010 contributions you elect will be posted to your account within 31 days after you enroll.
- **DCSA:** Contributions will be posted to your account each pay period. You can be reimbursed up to the amount available in your account. The balance of any claim will be paid as additional contributions are deposited into your account.
- **TRIP:** Contributions will be deducted each pay period to purchase transit and/or parking passes you've selected online.

Changing your contribution amounts

You may change your contributions for the HCSA, LPSA, and DCSA only during annual enrollment or as a result of a qualified change in status.

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

Legal requirement: Save your receipts

Each time you "swipe" your Health Care Spending Account Reimbursement Card (described in "Health Care Spending Account Reimbursement Card" on page 150), be sure to save your receipt in case you are required at a later date to substantiate that your expense was eligible for reimbursement under the Plan. *Per IRS rules, unsubstantiated expenses will be considered taxable income.*

You have until June 30, 2011, to resolve any 2010 transactions that require receipts. If you fail to resolve these transactions with the Citi Benefits Center by the deadline, the amount of the transaction in dispute, considered an "overpayment," will be added to the amount of your 2011 earnings. Applicable taxes will be withheld and reported on a Form W-2 (if you are an active employee) or a Form 1099-MISC (if you are no longer a Citi employee) at the time year-end tax forms are distributed.

Reimbursements

Reimbursements for eligible HCSA/LPSA and DCSA expenses will be deposited directly to your bank account, or sent via check to your home address, if no direct deposit account is on file. To add your direct deposit account information, visit Your Benefits Resources™ through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet. From the "Quick Links" page, click on Your Benefits Resources™. You also can go directly to **http://resources.hewitt.com/citigroup**.

If you HCSA or LPSA claim is denied, see "Claims and appeals for the HCSA/LPSA" on page 159.

Overpayments

In the event an expense reimbursed by any of the spending accounts is not eligible for reimbursement, you agree to reimburse Citi for any amount owed. In the event that amounts are owed under the HCSA, your privileges under the Health Care Spending Account Reimbursement Card may be subject to suspension or termination.

Spending accounts at a glance

SPENDING ACCOUNTS AT A GLANCE

	Health Care Spending Account (HCSA)	Limited Purpose Health Care Spending Account (LPSA)	Dependent Day Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Why enroll?	To reduce your taxes by paying for eligible expenses with pretax dollars			
What is reimbursed	IRS-qualified health care expenses for you and your family that are not paid by any medical, dental, or vision plan.	IRS-qualified vision, dental, and preventive care medical expenses for you and your family that are not paid by any medical, dental, or vision plan or your HSA.	IRS-qualified dependent day care expenses for your qualified dependents so that you (and your spouse, if you are married) can work or look for work.	Eligible transit and parking expenses. **Note:** Your contributions are used to purchase transit/parking passes online. There is no claim-filing process.
Contribution limits	From $120 to $15,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	From $120 to $5,000 per year per family; money is deducted in equal amounts each pay period.	**Transit:** Up to $230 per month **Parking:** Up to $230 per month
Forfeiture provisions	You will forfeit any money you contribute but do not use each calendar year.	You will forfeit any money you contribute but do not use each calendar year.	You will forfeit any money you contribute but do not use each calendar year.	If your account remains inactive for 12 consecutive months, you will forfeit any remaining contributions.

SPENDING ACCOUNTS AT A GLANCE				
	Health Care Spending Account (HCSA)	Limited Purpose Health Care Spending Account (LPSA)	Dependent Day Care Spending Account (DCSA)	Transportation Reimbursement Incentive Program (TRIP)[1]
Changing your election	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your election as the result of a qualified status change; you cannot enroll in December for the current year.	You can change your online purchase at any time; the change will be effective as soon as administratively possible.
Filing a claim	You must file claims for 2010 expenses so they are postmarked no later than June 30, 2011.	You must file claims for 2010 expenses so they are postmarked no later than June 30, 2011.	You must file claims for 2010 expenses so they are postmarked no later than June 30, 2011.	Claims for eligible expenses incurred through February 2010 must be filed no later than March 31, 2010.[2]

1 TRIP is not part of annual enrollment. You can enroll in TRIP at any time.

2 Beginning in March 2010, TRIP transit and parking passes must be purchased online.

Health Care Spending Account (HCSA)

You can contribute between $120 and $15,000 a year on a pretax basis to reimburse yourself for eligible out-of-pocket health care expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

You must actively elect to participate in the HCSA during each annual enrollment or within 31 days of a qualified change in status. You may enroll in the HCSA if you are *not* enrolled in a High Deductible Health Plan.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year.

HCSA claims must be filed by June 30 of the calendar year following the calendar year in which the expense was incurred. You may change or stop your contributions as a result of a qualified change in status.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the HCSA is not deemed to discriminate in favor of highly compensated employees.

Under the Heroes Earnings Assistance Relief Tax Act of 2008, if you are a reservist called to active military duty for more than 179 days on or after January 1, 2010, you are entitled to receive a taxable distribution of your HCSA 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.

Rules and features

General rules about expenses

Most health care expenses that the Internal Revenue Service (IRS) considers as deductible on your income tax return are eligible for reimbursement from the HCSA, provided the expenses are not reimbursed from any other source.

You can be reimbursed for your expenses or those incurred by anyone you can claim as a dependent on your tax return, regardless of whether you or your dependent is covered under any Citi medical, dental, or vision Plan.

Estimate expenses conservatively. You cannot receive a refund for contributions intended to reimburse yourself for a surgery or procedure that is later canceled.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your medical, dental, and/or vision plan, such as deductibles, coinsurance, and copayments;
- Other charges that exceed what your medical, dental, and/or vision plan will pay, such as charges above reasonable and customary amounts or other plan limits;

- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, that are not covered by your medical or vision plan;
- Hearing care expenses, such as exams, hearing aids, and hearing aid batteries, that are not covered by your medical plan;
- Certain equipment and training for disabled individuals;
- Childbirth classes, such as Lamaze, for up to two people;
- Chiropractic care that is not covered by your medical plan;
- Physical therapy, psychiatric therapy, and counseling that are not covered by your medical plan;
- Cholesterol tests, vaccines, and immunizations that are not covered by your medical plan;
- Prescription contraceptives and infertility treatments that are not covered by your medical plan;
- Smoking cessation programs;
- Certain over-the-counter drugs for which you have a receipt (see the lists of eligibility requirements below);
- Medicines prescribed by a doctor that your medical plan or prescription drug program does not cover; and
- Transportation necessary to obtain certain health care services.

Eligible over-the-counter drugs

The following over-the-counter medicines are covered under the HCSA when used to treat a medical illness or condition:

- Allergy medicine (e.g., Claritin);
- Antacids (e.g., Prilosec);
- Anti-diarrhea medicine;
- BenGay, Tiger Balm, or other products for muscle pain or joint pain;
- Medicines used to treat insect bites;
- Calamine lotion, creams to treat poison ivy;
- Carpal tunnel wrist supports;
- Cold medicine;
- Cough drops and throat lozenges;
- Diabetic supplies, including test kits;
- First aid cream, Neosporin;
- Hearing aid batteries;
- Hydrocortisone cream, Benadryl;
- Laxatives;
- Medicines taken as sleeping aids;
- Motion sickness pills;
- Nicotine gum or patches for smoking cessation;
- Pain reliever;
- Pedialyte;
- Pills for individuals who are lactose intolerant;
- Pregnancy test kits;
- Reading glasses;
- Sinus medications and sprays;
- Special diaper rash ointments;
- Special ointment or cream for sunburn;
- Suppositories and creams for hemorrhoids;
- Thermometers;
- Visine, contact lens solutions, contact lens cleaners, and other eye products used to treat eye ailments; and
- Wart remover treatments.

Ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare, or Medicaid;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your doctor;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your doctor;

- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor;
- Cosmetics, toiletries, or toothpaste;
- Amounts you pay for medical and dental insurance premiums; and
- Long-term-care services including insurance premiums for long-term care insurance.

The following over-the-counter items are covered under the HCSA only when accompanied by a diagnosis of medical condition from a licensed physician. The physician's note must indicate your specific medical condition and that the over-the-counter item is the recommended treatment:

- Medicated shampoos (diagnosis of specific scalp infection other than dry scalp or dandruff);
- Weight-loss drugs/programs (items which replace normal food are not eligible)
- Feminine hygiene products;
- Sunscreen;
- Acne treatment;
- Glucosamine/chondroitin for arthritis;
- St. John's Wort;
- OTC hormone therapy;
- Dietary supplements/fiber supplements/vitamins are rarely reimbursable, but they may be eligible if they are used to treat a specific medical condition and are not for general health purposes (requires note from licensed physician); and
- Hormone therapy creams.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at 1-800-829-1040.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Health Care Spending Account Reimbursement Card

When you enroll in the HCSA, you must elect to receive a Health Care Spending Account Reimbursement Card to use at any provider that accepts MasterCard as a form of payment. **Note:** The Health Care Spending Account Reimbursement Card is not available for use with any of the other spending accounts. Once you elect to receive a card, the automatic claims submission feature, described below, will be turned off automatically.

Automatic claims submission

The following Plans will submit your claims to the HCSA administrator so you will be reimbursed automatically for many eligible expenses without having to file a claim:

- Aetna and Empire BlueCross BlueShield ChoicePlan 500;
- Oxford Health Plans PPO;
- Citigroup Prescription Drug Program; and
- MetLife Preferred Dentist Program (PDP).

However, if you elect to receive a Health Care Spending Account Reimbursement Card, the automatic claims submission feature will be turned off. Instead, claims submitted automatically will be used only to validate purchases made with the reimbursement card. You will then need to file a claim for any expenses for which you do not use your reimbursement card.

If you do not want to be reimbursed for your claims automatically, you may cancel automatic reimbursement or you may elect an HCSA card, which will turn off the automatic claims submission feature. You may change your election one time during the plan year on the Your Spending Account™ (YSA) website. You may access the YSA website through Your Benefits Resources™. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™." Select the "Health and Insurance" tab and select any spending account you wish to access. To access the YSA website, click on either "Manage Your Account" or "Your Spending Account."

Reimbursements

At any time, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using HCSA during an unpaid leave or after your termination of employment

You can continue your HCSA coverage under COBRA through the end of the calendar year. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond the start date of your leave or your termination date, respectively. However, you will have until the following June 30 to submit your claims for services incurred before the start date of your leave/your termination date.

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your total compensation *before* your spending account contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your HCSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your tax return if you have been reimbursed for the same expense through the HCSA.

Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

Filing a claim

See “How to file a claim” in the *Eligibility and Participation* section.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your 2010 claims, your envelope must be postmarked no later than June 30, 2011.

For more information

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 also can visit the Social Security Administration website at **www.socialsecurity.gov** for information on the taxable wage base for a given year and Social Security plans and provisions.

Limited Purpose Health Care Spending Account (LPSA)

You must be enrolled in the Citi High Deductible Health Plan-Basic or Premier to enroll in the LPSA. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in the LPSA in December for the current calendar year. You may change or stop your contributions as a result of a qualified change in status.

Rules and features

You can contribute between $120 and $5,000 a year on a pretax basis to reimburse yourself for eligible out-of-pocket dental, vision, and preventive care medical expenses. Contributions are taken each pay period before federal and, in most locations, state and local taxes are withheld.

General rules about expenses

Since the LPSA is intended to be used in conjunction with a Health Savings Account, eligible expenses are limited to those for dental, vision, and preventive care medical expenses. Other medical care expenses should be paid from your HSA.

Examples of eligible health care expenses

- Your share of expenses that are not paid by your dental and/or vision plan, such as deductibles, coinsurance, and copayments and charges that exceed reasonable and customary amounts or other plan limits;
- Vision care expenses, such as exams, prescription eyeglasses and sunglasses, contact lenses, and laser surgery, which are not covered by your medical or vision plan;
- Preventive care medical expenses as identified by the IRS, such as:
- Periodic health evaluations, including tests and diagnostic procedures ordered in connection with routine examinations, such as annual physicals;
- Routine prenatal and well-child care;
- Child and adult immunizations;
- Tobacco cessation programs;
- Obesity weight-loss programs; and
- Screening services including routine cancer, heart disease, and infectious disease screening.
- Since network preventive care is covered at 100% in the High Deductible health Plan, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network doctor, the High Deductible Health Plan will cover 100% of reasonable and customary charges only. As a result, not all preventive care charges may be covered.

Ineligible health care expenses

- Expenses for which you have been reimbursed from another source, such as Citi's or another employer's medical, dental, and/or vision plan, Medicare or Medicaid, or your Health Savings Account;
- Non-preventive-care medical expenses;
- Elective cosmetic surgery or cosmetic dental work;
- Vitamins or minerals taken for general health purposes, including those recommended by your doctor;
- Maternity clothes or diaper services;
- Nursing services to care for a healthy newborn;
- Household help or custodial care at home or in an institution, even if recommended by your doctor;
- Health club fees, exercise classes, or weight-loss programs for general health purposes, even if recommended by your doctor;
- Cosmetics, toiletries, or toothpaste;
- Amounts you pay for medical and dental insurance premiums; and
- Long-term-care services including insurance premiums for long-term care insurance.

For more information

For more information about eligible expenses, see *IRS Publication 502: Medical and Dental Expenses* at **www.irs.gov** or contact your tax adviser. You also can call the IRS at 1-800-829-1040.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Is the Limited Purpose Health Care Spending Account for you?

The Limited Purpose Health Care Spending Account (LPSA) is for employees who enroll in the High Deductible Health Plan-Basic or Premier.

Generally, employees who enroll in the High Deductible Health Plan and establish a Health Savings Account also enroll in an LPSA to pay for eligible health care expenses with pretax dollars. ("Establish" an account means you apply for an account and are approved because you meet certain credit and "know your customer" requirements. If your account is not established, you cannot receive the employer contribution.) However, you may enroll in an LPSA if you are not enrolled in a Health Savings Account (as long as you are enrolled in the High Deductible Health Plan).

Note: Employees who enroll in a High Deductible Health Plan or who establish a Health Savings Account are *not* eligible to enroll in a Health Care Spending Account.

Plan your LPSA contributions accordingly

Since network preventive care is covered at 100% in the High Deductible Health Plan, you will not need this account to reimburse yourself for network preventive medical care expenses. However, if you obtain preventive care from an out-of-network doctor, the High Deductible Health Plan will cover 100% of reasonable and customary charges only. As a result, not all preventive care charges may be covered.

To participate in the LPSA each year you must actively enroll. Your enrollment does not carry over from year to year.

You can be reimbursed for expenses incurred only during the time you are enrolled. The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines, the Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants to ensure that the LPSA is not deemed to discriminate in favor of highly compensated employees.

Paying for your expenses out of pocket

You can submit claims for certain expenses under the following plans:

- High Deductible Health Plan-Basic and Premier;
- Dental; and
- Vision.

However, you must pay for expenses out of pocket and submit qualified expenses for reimbursement using the LPSA Claim Form (Form 315).

Reimbursements

At any time, you may be reimbursed for eligible expenses up to the total amount you elected to contribute for the Plan year. If you increase your contributions during the year because of a qualified change in status, you may be reimbursed from the increased amount only for expenses incurred *after* the date of the qualified change in status.

Using LPSA during an unpaid leave or after your termination of employment

If you terminate employment with Citi, you can continue your LPSA coverage under COBRA through the end of the calendar year in which your employment was terminated. If you do not continue coverage under COBRA, you cannot use the account for expenses incurred beyond your termination date. However, you will have until the following June 30 to submit your claims.

Effect on other benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your total compensation *before* your spending account contributions are deducted.

Effect on taxes

You receive a tax advantage by paying for eligible health care expenses through your LPSA *or* by claiming a federal income tax deduction for eligible expenses that exceed 7.5% of your adjusted gross income. However, you cannot claim a deduction for an expense on your tax return if you have been reimbursed for the same expense through the LPSA.

Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

Filing a claim

See “How to file a claim” in the *Eligibility and Participation* section.

Generally, you will have until June 30 following the year in which you incur the eligible expense to file a claim for reimbursement. If mailing your 2010 claims, your envelope must be postmarked no later than June 30, 2011.

For more information

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 also can visit the Social Security Administration website at **www.socialsecurity.gov** for information on the taxable wage base for a given year and Social Security plans and provisions.

Dependent Day Care Spending Account (DCSA)

You can contribute between $120 and $5,000 a year on a pretax basis to reimburse yourself for day care expenses for qualified dependents so that you (and your spouse, if you are married) can work or look for work. See “Qualifying individuals” on page 155.

You can be reimbursed for expenses incurred only during the time you are enrolled. You can enroll as a new employee, during the annual enrollment period, or within 31 days of a qualified change in status. However, you cannot enroll in December for the current calendar year.

The amount of your payroll contributions will appear on your Form W-2 Wage and Tax Statement for the year in which you were enrolled.

In accordance with IRS guidelines:

- The Plan Administrator, in its discretion, may reduce the rate of contribution by certain participants during the year to ensure that the DCSA is not deemed to discriminate in favor of highly compensated employees.
- Eligible expenses submitted via paper claim with future dates of service will not be reimbursed prior to the last day of the billing period.

Quick tip: You cannot use the DCSA to reimburse yourself for your dependents’ health care expenses; use the HCSA for that purpose.

Rules and features

Examples of eligible dependent day care expenses

- Care at a licensed nursery school, day camp (including specialty camps), or day care center; the facility must comply with state and local regulations, serve more than six individuals, and receive fees for services;
- Services from individuals who provide dependent day care in or outside your home, unless the provider is your spouse, your own child under age 19, or any other dependent (these individuals must provide their Social Security numbers to you);
- After-school care for children under age 13;
- Household services related to the care of an elderly or disabled adult who lives with you;
- Expenses for a care provider for the transportation between your house and the place that provides day care services;
- Your portion of FICA and other taxes that you pay for a care provider; and
- Any other services that qualify as dependent day care under IRS rules.

Examples of ineligible dependent day care expenses

- Expenses for food, clothing, or education;
- Expenses for transportation between your house and the place that provides day care services;
- Expenses for dependent day care when either you or your spouse is not working;
- Charges for convalescent or nursing home care for a parent or disabled spouse;
- Overnight camp expenses;

- Expenses for dependent day care that enables you or your spouse to do volunteer work;
- Payments made to your spouse, your own child under age 19, or any other dependent; and
- Expenses for which you take the federal child care tax credit.

For more information

For more information about eligible dependents and expenses, see *IRS Publication 503: Child and Dependent Care Expenses* at www.irs.gov or contact your tax adviser. You also can call the IRS at 1-800-829-1040.

Note: The IRS publication is a guideline for use in preparing tax returns; it is not a description of the Citi Plan.

Qualifying individuals

According to IRS rules, you may be reimbursed only for expenses incurred in caring for a qualifying individual. Generally, a qualifying individual includes:

- Each of your children under age 13 who must share your residence for more than half the year and who must not provide more than half of his or her own support;
- Your spouse who is physically or mentally unable to care for himself or herself and resides with you for more than half the year; and
- Dependents who are mentally or physically unable to care for themselves, reside with you for more than half the year, and who have gross income of less than the dependency exemption threshold ($3,650 in 2009).

Marital status and your DCSA contribution

If you file a joint tax return: You and your spouse together may contribute up to $5,000 a year before taxes to DCSAs. For example, if your spouse contributes $2,000 to his or her employer's DCSA, you can contribute up to $3,000 to yours. If either you or your spouse earns less than $5,000 annually, the combined amount you and your spouse contribute cannot exceed the lower salary.

If you file separate tax returns: You and your spouse each may contribute up to $2,500 a year before taxes to your respective DCSA.

If your spouse does not work: In general, you cannot use the DCSA if your spouse does not work, unless he or she is a full-time student for at least five months during the calendar year, is looking for work, or is disabled.

To determine the maximum contribution in these cases, your spouse is considered to earn $250 a month if you have one qualified dependent or $500 a month if you have two or more qualified dependents. For Plan purposes, count only the months that your spouse is either in school or disabled.

These limits are subject to change.

Reimbursements

You cannot be reimbursed for expenses that exceed the amount of your contributions.

If your claim exceeds your current account balance, you will be reimbursed up to your account balance. Any outstanding amount of your claim will be paid to you automatically after the next pay period when new contributions are added to your account until the total amount is paid or the money in your account is depleted.

The maximum you can receive tax-free from your DCSA is reduced by the value of any employer-provided day care you use, whether provided through Citi or your spouse's employer.

For example, if you receive a DCSA subsidy of $1,000, then you can receive up to $4,000 tax-free from your DCSA. If you contribute more than $4,000, any amount reimbursed above $4,000 will be included as taxable income on your Form W-2 Wage and Tax Statement for that year.

Effect on other Citi benefits

Even though you reduce your taxable income by using the spending account(s), you are not reducing your pay for determining any Citi pay-related benefits, such as disability or life insurance. Benefits under these Plans are based on your compensation before your spending account contributions are deducted.

Effect of DCSA participation on Social Security

Your spending account contributions will reduce the amount of your Social Security taxes. If your taxable pay is below the Social Security taxable wage base, your future Social Security retirement benefits also may be reduced.

Using DCSA after your termination of employment

You may submit claims for eligible expenses incurred after your termination date but within 2010. You must submit any eligible 2010 claims no later than June 30, 2011.

DCSA subsidy

If you are eligible *and* you elect the DCSA subsidy during enrollment (either as a new hire or during annual enrollment), Citi will pay up to 30% of your DCSA contribution. The percentage will depend on the amount of your total compensation and whether you work part-time or full-time.

Alert: To obtain the DCSA subsidy you must elect it; it is not automatic.

You are eligible for a subsidy if you enroll in the DCSA and on your enrollment date:

- **If you are a sole financial provider:** Your total compensation *and* your total annual household income together do not exceed $90,000, or
- **If you are in a dual-income household:** Your total compensation does not exceed $45,000 *and* your total annual household income does not exceed $90,000.

You must enroll for the subsidy during your enrollment period. You cannot receive the subsidy through any other process. You must elect the full amount that you want to use to reimburse yourself for eligible expenses. The deductions from your pay will be the amount of the election minus the amount of the subsidy.

The amount of your subsidy will not change during the year even if you change your DCSA contribution amount as a result of a qualified change in status. Your subsidy will be credited to you during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible for benefits.

You cannot become eligible for the DCSA subsidy midyear as a result of a qualified change in status, such as a divorce or death of your spouse.

If your total compensation is*:	Your DCSA subsidy will be:	
	For full-time employees	For part-time employees
Up to $25,000	30% of your DCSA contribution; maximum subsidy is $1,500	22-1/2% of your DCSA contribution; maximum subsidy is $1,125
$25,001-$35,000	20% of your DCSA contribution	15% of your DCSA contribution
$35,001-$45,000	15% of your DCSA contribution	11-1/4 % of your DCSA contribution
$45,001-$90,000 if you are the sole financial provider of your dependents	15% of your DCSA contribution	11-1/4 % of your DCSA contribution

* And your total household income does not exceed $90,000 at the time you enroll.

If you are rehired

If you terminate employment with Citi and are rehired in the same year, you must re-enroll to have DCSA coverage. If you re-enroll in the DCSA, you are not eligible for the subsidy since your subsidy was credited during your employment earlier in the same year. (Subsidies are credited during the first quarter if you enroll during annual enrollment or within 31 days after you enroll as a new hire or newly eligible for benefits.)

Filing a claim

See “How to file a claim” in the *Eligibility and Participation* section.

Generally, you will have until June 30 following the year in which you incur an eligible expense to file a claim for reimbursement. For example, you will have until June 30, 2011, to file claims for reimbursement of expenses incurred in 2010. (Your envelope must be postmarked no later than June 30, 2011.)

Note: You cannot submit claims for reimbursement more than two weeks in advance of the service date. Claims submitted more than two weeks in advance will be denied as ineligible and you will need to resubmit them to be reimbursed.

For more information

Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare" benefits option.

Transportation Reimbursement Incentive Program (TRIP)

TRIP allows you to purchase transit and parking passes online with pretax, and if needed, after-tax dollars. These passes are used so you can commute to and from work; they are not to be used on business travel, for example, to use public transportation to attend a business meeting. By enrolling in TRIP, you lower your taxable income and, as a result, pay less in federal and FICA taxes, and, in most locations, state and local taxes.

You can set up or change your online purchase at any time. Your enrollment or change will be effective as soon as administratively possible.

How the program works

Are you eligible to enroll in TRIP?

You are eligible to enroll in TRIP if:

- You commute to work by public transportation (bus, subway, train, ferry, or van pool) or you commute to work by car and have out-of-pocket parking expenses.
- You do *not* participate in a Company-sponsored parking or mass transportation program.

If you enroll in TRIP and later begin participating in a Company-sponsored parking or mass transportation program, you must cancel the purchase of your online transit or parking pass.

TRIP is made up of two accounts:

- **A Transit Account** to pay for eligible transit expenses. The Code defines transit expenses as those for bus, subway, train, metro passes, ferry, and van pooling. A van must be a "licensed commuter highway vehicle" with seating capacity of six or more adults, excluding the driver.
- **A Parking Account** to pay for parking on or near Citi's business premises or near a location from which you commute to work by mass transit, van pool, or car pool.

You can enroll to purchase both transit and/or parking passes online, depending on what is required for your commute to and from work. When enrolling, you can set up a recurring purchase or you can arrange to purchase your pass each month. The pass will be mailed to your home in time for use beginning the first of the following month.

The deadline to enroll or change your TRIP participation is the 10th of every month for participation the first of the following month. If you miss the deadline, your enrollment/change will be effective the following month.

Once enrolled, you can cancel or suspend your online purchase at any time. If you cancel or suspend your purchase by the 10th of any month (the monthly purchase deadline), a pass will not be purchased for you for the following month.

The first $230 of the cost of your transit and/or parking pass will be deducted from your pay before taxes are withheld. Any amount of your pass(es) that exceeds $230 will be deducted from your pay after taxes are withheld.

If you:	Order:	Receive:
Enroll to purchase a transit and/or parking pass on the Your Spending Account™ (YSA) website, available as link from Your Benefits Resources™.	No later than the 10th of any month **Note:** The YSA website will first be available beginning January 11, 2010, for the purchase in February of March passes.	Your pass will be purchased and mailed to your home address on Citi records so you have it before the first of the following month.

Important reminder: Claims for eligible TRIP expenses incurred through February 28, 2010, must be submitted to ADP, the TRIP administrator through early 2010, no later than March 31, 2010. After that time, you can no longer submit any paper claims for TRIP expenses. Any claims that are postmarked after March 31, 2010, will be denied.

EXAMPLES OF ELIGIBLE EXPENSES	
Parking Account	Transit Account
Parking at or near your work location and Parking at or near a location from which you commute to work by mass transportation, car pool, or other means	• Transportation passes; • Any pass, token, fare card, ticket, or similar item that entitles you to ride public transportation to and from work; • Transportation between work and your residence in a "commuter highway vehicle" that: – Seats six or more adults excluding the driver; – Is used 80% or more (based on mileage) for transporting employees between work and home; and – Includes at least three commuters, excluding the driver, on each trip.

EXAMPLES OF INELIGIBLE EXPENSES	
Parking Account	Transit Account
• Non-work-related parking expenses; • Parking at or near your residence; • Parking for which you receive a pretax benefit; • Parking paid for by your employer; • Parking expenses incurred by family members; and • Expenses eligible to be reimbursed from the Transit Account.	• Car pooling and/or van pooling in a vehicle seating fewer than six passengers, excluding the driver; • Taxi fares; • Highway, bridge, or tunnel tolls; • Expenses incurred for business travel (such as traveling from the office to a business or client meeting); • Gas or mileage expenses; • Transit expenses incurred by family members; and • Expenses eligible to be reimbursed from the Parking Account.

Changing your TRIP pass election

Once enrolled, you can change your online purchase at any time; the change will be effective as soon as administratively possible. For example, you are enrolled to purchase a parking pass and a train pass. Then you relocate so you require a bus pass only. If, by May 10 (for example), you cancel the train and parking pass purchase and enroll for a bus pass, your new bus pass will be mailed to your home address on Citi records for use as of June 1.

To enroll in TRIP or to change your election once enrolled, visit the Your Spending Account (YSA) website through the Your Benefits Resources™. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™." From the "Manage your spending accounts" section, click on the link for "Your Spending Accounts."

Tax exemptions

TRIP accounts are exempt from all federal income and employment taxes and most state and local taxes. If you live in a state that does not exempt TRIP contributions from state or local tax, you will be taxed on the benefit. The amount reported as "state wages" on your Form W-2 Wage and Tax Statement for the year of the contribution will be higher than the amount reported for federal wages.

If your employment is terminated

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.

Filing a claim

You can file a claim for eligible transit and/or parking expenses incurred through February 28, 2010, no later than March 31, 2010. Your claim must include itemized receipts or your claim will be denied. Beginning March 1, 2010, when the new online purchase process begins, no claims can be filed.

For more information

Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. Representatives are available from 8 a.m. to 8 p.m. Eastern time on weekdays.

Claims and appeals for the HCSA/LPSA

If you are denied a benefit under the HCSA/LPSA, you should proceed in accordance with the following procedures.

Step 1: Denial Notice is received from the Citi Benefits Center. If your claim is denied, you will receive written notice from the Citi Benefits Center that your claim is denied as soon as reasonably possible but no later than 30 days after receipt of the claim. For reasons beyond the control of the Citi Benefits Center, it may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to obtain that information. The time period during which the Citi Benefits Center must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: Once you have received your notice from the Citi Benefits Center, review it carefully. The notice will contain:

- The reason(s) for the denial and the Plan provisions on which the denial is based;
- A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- A description of the Plan's appeal procedures and the time limits applicable to such procedures;
- A right to request all documentation relevant to your claim; and
- A statement explaining your rights to bring civil action under Section 502(a) of ERISA after an adverse benefit determination upon review.

Step 3: If you disagree with the processing of your claim, contact the Citi Benefits Center for assistance. If you are still unable to resolve your issue and have your claim approved, you may file a Level 1 appeal. You may obtain a Level 1 appeal form from the Citi Benefit Center spending account team. Complete and return the form along with any additional supporting documentation on why you believe your claim should be approved to the address shown on the first page of the form.

You should file your appeal no later than 180 days after receipt of the notice described in Step 1. You should file your appeal with the Citi Benefits Center at the address provided below. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

Your Spending Account BDRT
P.O. Box 1444
Lincolnshire, IL 60069-1444

Step 4: Notice of Denial is received from claims reviewer. If the claim is again denied, you will be notified in writing. The notice will be sent no later than 30 days after receipt of the appeal by the Citi Benefits Center.

Step 5: Review your notice carefully. You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the third-party administrator.

Step 6: If you still do not agree with the Citi Benefits Center's decision, you may file a written appeal with Citi at the address listed below within 60 days after receiving the latest denial notice from the Citi Benefits Center. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe would support your claim.

If Citi denies your appeal, you will receive notice within 30 days after the Citi receives your claim. The notice will contain the same type of information that was referenced in Step 1 above.

Citigroup Inc.
Plans Administration Committee of Citigroup Inc.
1 Court Square, 46th Floor
Long Island City, NY 11120

Disability Coverage

The Disability Plan provides for a Short-Term Disability (STD) and a Long-Term Disability (LTD) benefit to replace a portion or all of your earnings if you are unable to work due to an illness, injury, or pregnancy.

This section of Benefits Book Online briefly describes the STD and LTD benefits available, but this section is not the plan document for either of these plans. The receipt of STD and LTD benefits is subject to the terms and conditions of the applicable Plan. For related benefit offsets, exclusions, and limitations, see the Plan document at **https://www.benefitsbookonline.com/Disability_Plan_Document.pdf**, available from the Citi intranet and the Internet, and the insurance certificate at **https://www.benefitsbookonline.com/MetLife_Cert.pdf**. This section is not intended to be a substitute for the actual Plan documents.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the Plan document at no cost to you by speaking with a Citi Benefits Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu choose the “health and welfare benefits” option.

Definition of years of service for the Plan (STD and LTD benefits)

For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citi as an employee. You are credited with service from your hire date, or if you have had one or more breaks in service, from your adjusted service date. You will have a year of service for this purpose for each 12 months of service, counting any part of a month in which you provided service.

Service before a break in service will be allowed (or not) under rules similar to the Citigroup Pension Plan credited service rules, such as not counting service prior to five consecutive one-year breaks in service. In no event will the time between your periods of Citi service be counted.

Contents

Short-Term Disability (STD) 161

When STD benefits are payable 162

Long-Term Disability (LTD) 163

When LTD benefits are payable 164

Short-Term Disability (STD)

The STD benefit is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Claims Administrator before you can receive a benefit. Call Met Life to report your disability, Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu choose the “Managed Disability” option. You also can call MetLife directly at 1-888-830-7380.

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

STD SCHEDULE OF BENEFITS FOR BENEFITS-ELIGIBLE SALARIED EMPLOYEES			
Years of service	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of base salary
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

Disability Coverage

For Account Executives in the Institutional Clients Group the following schedule of benefits applies:

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

Pregnancy leave for benefits-eligible salaried employees			
Years of service	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of benefit
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 or more years	13	0	13

Pregnancy leave for benefits-eligible commission-paid Account Executives				
Years of service	Minimum benefit (% of total compensation)	Plus additional benefit	Maximum benefit (% of total compensation)	Total weeks of benefit
Less than 1 month	0	0	0	0
1 month to less than 1 year	70%	Commissions	100%	13
1 or more years	80%	Commissions	100%	13

For employees paid on commission working in Consumer Banking and North America Cards: You will receive STD benefits based on a phantom salary (and not based on total compensation). If any commissions are generated while you are on an STD leave, they will be paid in addition to the STD benefit based on your years of service.

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

When STD benefits are payable

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

You are not considered to have a disability if your illness, injury, or pregnancy prevents you from commuting to and from work only. To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You cannot qualify for STD benefits if you return to work on a part-time basis unless you work in California or New Jersey, in which case you will receive benefits under your state plan.

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

For employees who work in California

If you are eligible for disability benefits, you are covered by the Citigroup California Voluntary Disability Insurance (VDI) Plan, unless you reject the plan. The VDI Plan replaces the state plan. For details, ask your HR representative.

If you are covered by the VDI plan, you are not eligible to file a claim with the state. You must report your disability to MetLife. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu choose the "Managed Disability" option. You also can call MetLife directly at 1-888-830-7380.

Long-Term Disability (LTD)

LTD coverage is offered to replace 60% of your total compensation (predisability earnings) as of the day before your approved disability when your disability continues for more than 13 weeks, as set forth in the MetLife certificate. For purposes of calculating your LTD benefit, total compensation is limited to a maximum of $500,000.

Citi provides Company-paid LTD coverage to employees whose total compensation is less than or equal to $50,000.99. If your total compensation is $50,001 and above and you want LTD coverage, you must enroll and pay for it. The cost of LTD coverage is shown on the Your Benefits Resources™ web site during annual enrollment.

If you have been enrolled in the Plan for one year and leave Citi (other than to retire, which could occur if you terminate employment after 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), you can convert your Citi LTD coverage under the group policy to an individual policy within 31 days after your employment ends.

The maximum benefit of this individual policy is $3,000 per month. To obtain conversion information, call the Citi Benefits Center through ConnectOne. Call 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

If your total compensation is:	
$50,000.99 or less*	Citi provides LTD coverage at no cost to you.
From $50,001 to $500,000	To have LTD coverage, you must enroll. You will pay for coverage with after-tax dollars.

* If your total compensation increases above $50,000.99 during the year and you want LTD coverage for the following year, you must enroll during annual enrollment; otherwise, you will not have LTD coverage as of the first of the following year. You do not have to provide evidence of good health to enroll in LTD at this time.

You may be eligible to receive LTD benefits after 13 weeks of an approved STD leave. Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins). See the following schedule. You will be billed for your health and welfare benefits, to the extent you are enrolled. The cost of benefits is not deducted from your LTD benefit. For details, see the Managed Disability brochure on the Citi intranet at **www.citigroup.net/human_resources/materials.htm**.

Unless you have other disability coverage, you should consider enrolling in LTD since LTD coverage protects you in the event your ability to work is impaired by an accident or illness.

You do not have to enroll in LTD coverage. However, if you decide to enroll in LTD coverage at any time other than when first eligible (either within 31 days of your date of hire/date you become eligible for Citi benefits or during annual enrollment for the plan year after your total compensation exceeds $50,000.99) or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health.

Note: The Plan will not cover any disability caused by, contributed to, or resulting from a pre-existing condition until you have been enrolled in the Plan for 12 consecutive months.

LTD BENEFITS	
Age when total disability begins	Date monthly LTD benefits will stop
Under 60	Upon attaining age 65
60	The date the 60th monthly benefit is payable
61	The date the 48th monthly benefit is payable
62	The date the 42nd monthly benefit is payable
63	The date the 36th monthly benefit is payable
64	The date the 30th monthly benefit is payable
65	The date the 24th monthly benefit is payable
66	The date the 21st monthly benefit is payable
67	The date the 18th monthly benefit is payable
68	The date the 15th monthly benefit is payable
69 or over	The date the 12th monthly benefit is payable

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

When LTD benefits are payable

For purposes of initially qualifying for LTD benefits, a disability means that due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment from an attending physician on a continuing basis and are unable to perform your own occupation for any employer in your local economy. After a period up to 60 months, and depending on your predisability earnings, you may continue to qualify for benefits if you are unable to earn more than 60% of your predisability earnings at any occupation for which you are reasonably qualified.

LTD benefits become payable after you are approved for and receive 13 weeks of continuous STD benefits. To qualify for LTD benefits, you must be under the continuous care of an attending physician during the STD period.

Insurance Benefits

Citi provides the opportunity for you to purchase several kinds of insurance at group rates for your safety and security and that of your dependents:

- Group Universal Life (GUL)/Accidental Death and Dismemberment (AD&D) insurance for you and your spouse (whether same or opposite sex)/civil union partner/domestic partner;
- Term life insurance for your children; and
- Long-Term Care insurance.

In addition, certain employees are eligible to receive Basic Life/AD&D insurance at no cost to them.

All regular full-time and part-time employees are also covered under the Business Travel Accident/Medical Plan, which pays benefits in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. In addition, the Business Travel Medical program provides non-routine and emergency medical coverage while traveling on business for Citi.

Not the plan document

This section of Benefits Book Online briefly describes the insurance plans, but it is not the plan document for any of the plans.

Contents

Basic Life/AD&D insurance 165

If your total compensation is increased to $200,000 or above 166

Basic Life accelerated benefits option 166

Converting to an individual policy 166

GUL/Supplemental AD&D insurance 166

GUL accelerated benefits option 167

Cash Accumulation Fund 167

Coverage for your spouse (whether same or opposite sex)/civil union partner/domestic partner 168

Life/AD&D insurance for your children 168

Additional details about AD&D insurance 168

Business Travel Accident/Medical insurance 170

Converting to an individual policy 171

Long-Term Care (LTC) insurance 171

Enrolling in LTC coverage 172

When LTC benefits are payable 172

Benefits and services covered 172

Choosing a level of coverage 172

Choosing a non-forfeiture LTC benefit or a contingent non-forfeiture LTC benefit 173

Choosing inflation protection: ABI or future purchase option 173

Additional features 174

Coordination of benefits and exclusions 175

Tax implications 175

For more information 175

Basic Life/AD&D insurance

Citi provides Basic Life insurance (through MetLife) and Accidental Death and Dismemberment (AD&D) insurance (through CIGNA) at no cost to you if your total compensation is less than $200,000. AD&D pays a benefit if you are dismembered or die as a result of an accidental injury. If your annual total compensation is equal to or above $200,000, you are *not* eligible for company-paid Basic Life/AD&D insurance.

The benefit is equal to your total compensation, rounded up to the nearest $1,000, to a maximum of $200,000. Total compensation is recalculated each year, and the new amount is effective each January 1.

Since Citi pays the full cost of Basic Life insurance, you must pay taxes on the value of the coverage above $50,000 as required by the IRS. This amount, called "imputed income," is shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. Imputed income is not a deduction but an amount added to your taxable pay based on the amount of Basic Life insurance coverage above $50,000.

If your total compensation is more than $50,000, you may elect to limit your Basic Life insurance to $50,000. You will not be subject to the imputed income, but you will also forego the additional benefit. You will not have the opportunity to enroll in Basic Life equal to your total compensation or to reduce coverage until the next annual enrollment period.

If your total compensation is increased to $200,000 or above

Once your total compensation is equal to or exceeds $200,000, you may have the opportunity to enroll in Group Universal Life (GUL) coverage equal to one times your total compensation up to $500,000 *without providing evidence of good health,* subject to the Plan's maximum coverage limits.

If you are enrolled in GUL up to the maximum coverage amount — the lesser of 10 times your total compensation or $5 million — then you are not eligible to increase GUL coverage.

Basic Life accelerated benefits option

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

Under the ABO, you may receive up to 50% of your Basic Life amount, not to exceed $100,000, less any applicable expense charges. The minimum amount that will be paid is the lesser of 25% of your Basic Life amount or $5,000. The accelerated benefit will be paid in a lump sum unless you or your legal representative selects another payment method.

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

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

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

Converting to an individual policy

You can convert your Basic Life/AD&D to an individual policy by contacting the Citi Benefits Center within 31 days after your termination of employment from Citi. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

If you become ineligible for Basic Life/AD&D coverage because your total compensation for the Plan year equals or exceeds $200,000, you can convert your current Basic Life/AD&D coverage to an individual policy — without providing evidence of good health — by contacting the Citi Benefits Center within 31 days after the Citi Benefits Center notifies you that you are no longer eligible for Basic Life coverage.

GUL/Supplemental AD&D insurance

You can enroll in GUL insurance (provided by MetLife) from one to 10 times your total compensation up to a maximum coverage amount of $5 million. If your total compensation is not an even multiple of $1,000, your coverage amount will be rounded up to the next $1,000.

Your cost is based on the amount of coverage you elect, your age, and whether you have used tobacco products in the past 12 months. The cost of coverage is deducted from your pay.

If you are enrolling outside your initial eligibility period (31 days from your date of hire/date you are eligible to enroll in Citi benefits), or for an amount greater than three times your compensation or $1.5 million, you must provide evidence of good health and be actively at work before coverage will be effective. Actively at work means that you are regularly scheduled to work in the office or at home and you are not away from work due to a disability. You must be able to perform all the activities of your job.

Enrolling in GUL coverage

You do not enroll for GUL coverage through Citi. Instead, you enroll in GUL coverage by contacting MetLife. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on the "MetLife MyBenefits Web Site" or submit an enrollment form, which you can obtain by calling MetLife at 1-800-523-2894. Spouse (whether same or opposite sex)/civil union partner/domestic partners must complete an enrollment form.

If your total compensation is reduced, your GUL amount will continue to be based on the higher total compensation unless you call MetLife at 1-800-523-2894 to request that the GUL amount be reduced. Once you reduce coverage, you can increase it only by purchasing additional multiples of your total compensation. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective.

Once enrolled in GUL, you automatically will receive Supplemental AD&D coverage in the same amount as your GUL coverage. Supplemental AD&D coverage is provided by CIGNA.

If you leave Citi, you can continue coverage under an individual policy. MetLife will bill you directly at a higher rate than the Citi group rate. The rate will become effective in the month following your termination of employment. Your Supplemental AD&D coverage ends on the last day of the month in which your employment was terminated. To convert your Supplemental AD&D coverage to an individual policy, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative.

GUL accelerated benefits option

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

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

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

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

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

Accelerated benefits are not payable if:

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

Cash Accumulation Fund

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

The IRS determines the annual maximum you can contribute based on your GUL coverage amount, your age, and other factors.

If your contributions for GUL, including the CAF, exceed the actual limits of the coverage for which you are enrolled, MetLife will notify you about a refund. For the actual amount that applies to you under the applicable tax laws, call MetLife at 1-800-523-2894.

You can change the amount of your CAF contribution at any time. **Note:** A decrease in coverage amounts could affect the amount you can contribute to your CAF.

You will not pay taxes on the interest while it remains in the CAF. The interest is taxable only when you withdraw more than the total you have paid up to that point for GUL coverage (your premiums) plus your CAF contributions.

For more information about the CAF, call MetLife at 1-800-523-2894.

Coverage for your spouse (whether same or opposite sex)/civil union partner/domestic partner

You can enroll in GUL insurance coverage for your spouse (whether same or opposite sex)/civil union partner/domestic partner in increments of $10,000 to a maximum of $100,000. You do not need to buy GUL/Supplemental AD&D for yourself to elect coverage for your spouse (whether same or opposite sex)/civil union partner/domestic partner.

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

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

The cost is based on the amount of your spouse's/civil union partner's/domestic partner's coverage, his or her age, and whether he/she has used tobacco products in the past 12 months. You can also contribute to a Cash Accumulation Fund in your spouse's/civil union partner's/domestic partner's name.

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

If you leave Citi or terminate your marriage, civil union, or domestic partnership, your spouse/civil union partner/domestic partner can continue coverage under an individual policy. MetLife will bill him or her directly at a higher rate than the Citi rate. The rate will become effective in the month following your termination of employment, divorce, or termination of your civil union or domestic partnership. Supplemental AD&D coverage terminates on the last day of the month in which the events noted above occur. Your spouse/civil union partner/domestic partner can convert his/her Supplemental AD&D coverage to an individual policy, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative.

Life/AD&D insurance for your children

If you have enrolled in GUL/Supplemental AD&D coverage for you or your spouse (whether same or opposite sex)/civil union partner/domestic partner, you can enroll for life/AD&D insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. *A child must be at least 14 days old to be covered.* Life insurance coverage is provided by MetLife. To enroll in child life coverage, call MetLife at 1-800-523-2894. When you enroll in child life coverage, all your eligible children are covered.

Separately, you must report the birth or adoption of each child to the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

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

Additional details about AD&D insurance

Schedule of covered losses

- Loss of life: 100% of the principal sum
- Loss of two or more hands or feet: 100% of the principal sum
- Loss of sight of both eyes: 100% of the principal sum

- Loss of one hand or one foot and sight in one eye: 100% of the principal sum
- Loss of speech and hearing (in both ears): 100% of the principal sum
- Quadriplegia: 100% of the principal sum
- Paraplegia: 75% of the principal sum
- Hemiplegia: 50% of the principal sum
- Loss of one hand or foot: 50% of the principal sum
- Loss of sight in one eye: 50% of the principal sum
- Loss of speech: 50% of the principal sum
- Loss of hearing (in both ears): 50% of the principal sum
- Loss of all four fingers of the same hand: 25% of the principal sum
- Loss of thumb and index finger of the same hand: 25% of the principal sum
- Loss of all the toes of the same foot: 20% of the principal sum

Additional accident benefits

- Felonious assault benefit for basic AD&D
  - Accidental death and dismemberment benefit: 10% multiplied by the percentage of the principal sum applicable to the covered loss, as shown in the schedule of covered losses, subject to a maximum of $100,000
  - Hospital stay benefit: $100 per day; maximum benefit period of 365 days per hospital stay per covered accident
- Seatbelt and airbag benefit
  - Seatbelt benefit: 10% of the principal sum subject to a maximum benefit of $25,000
  - Airbag benefit: 5% of the principal sum subject to a maximum benefit of $15,000
  - Default benefit: $1,000

Age reduction schedule

A covered person's principal sum will be reduced to the percentage of his principal sum in effect on the date preceding the first reduction, as shown below:

Age	Percentage of Benefit Amount
70 but less than 75	70%
75 but less than 80	45%
80 but less than 85	30%
85 or over	15%

Coverage for a child is not continued for 12 months if the child loses his or her status as a full time student.

Coverage for a spouse ends at age 70.

Exclusions

In addition to any benefit-specific exclusions, benefits will not be paid for any covered injury or covered loss which, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in the description of benefits section:

- Intentionally self-inflicted injury, suicide or any attempt thereat while sane or insane;
- Commission or attempt to commit a felony or an assault;
- Commission of or active participation in an insurrection; terrorist act or riot, (participation in a riot means taking part, joining or sharing with others in a violent disturbance of the public peace of persons assembled for a common purpose;
- Bungee jumping; parachuting; skydiving; parasailing; hang-gliding;
- Declared or undeclared war or act of war;
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the earth's surface:
  - Except as a passenger on a regularly scheduled commercial airline,
  - Being flown by the covered person or in which the covered person is a member of the crew,

  - Being used for:
    - crop dusting, spraying or seeding, giving and receiving flying instruction, fire fighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
    - designed for flight above or beyond the earth's atmosphere;
    - an ultra-light or glider;
    - being used for the purpose of parachuting or skydiving;
    - being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food;
- Travel in any aircraft owned, leased or controlled by the policyholder, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by the policyholder if the aircraft may be used as the policyholder wishes for more than 10 straight days, or more than 15 days in any year;
- A covered accident that occurs while engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Covered accidents that occur while engaged in Reserve or National Guard training are not excluded until training extends beyond 31 days;
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered accident occurred;
- Voluntary use of any controlled substance as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as now or hereafter amended, unless as prescribed by his physician; (accidental ingestion of a poisonous substance or controlled drug is not excluded);
- In addition, benefits will not be paid for services or treatment rendered by a physician, nurse or any other person who is:
  - Employed or retained by the policyholder;
  - Providing homeopathic, aromatherapeutic or herbal therapeutic services;
  - Living in the covered person's household;
  - A parent, sibling, spouse or child of the covered person.

Business Travel Accident/Medical insurance

Business Travel Accident/Medical insurance (BTA) pays benefits for bodily injury and/or death when a covered accident is incurred while traveling on company business. In addition to the BTA, the Business Travel Medical program provides non-routine and emergency medical coverage while traveling on business for Citi. Coverage is provided by ACE. All eligible employees have BTA coverage equal to five times total compensation to a maximum benefit of $2 million. Your spouse (whether same or opposite sex)/civil union partner/domestic partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

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

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

may be entitled to recover less than your total coverage amount.

If you suffer more than one loss in an accident, you will be paid only for the loss that provides the largest benefit. Each aircraft accident is subject to a maximum benefit limit, regardless of the number of covered persons who incur a loss or the severity of the loss.

Your BTA beneficiary, the person or persons designated to receive any benefit payable at your death, is the same beneficiary as for your Basic Life insurance. If you do not have Basic Life insurance, the beneficiary is your spouse (whether same or opposite sex)/civil union partner/domestic partner, then your children, and then your estate.

Converting to an individual policy

You can convert your BTA coverage to an individual AD&D policy within 31 days of your termination of employment from Citi if you are under age 70 and you submit an application and appropriate premium. The coverage under the individual policy must be for at least $25,000 and cannot be more than the greater of the amount of your employee coverage or $500,000.

Long-Term Care (LTC) insurance

You can purchase LTC coverage for you and eligible members of your family at any time. Coverage is provided by the John Hancock Life Insurance Company.

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

- Your spouse (whether same or opposite sex), civil union partner, or domestic partner;
  - Note that coverage is not available to domestic partners residing in Louisiana.
- Your parents or your parents-in-law;
- Your adult children or the adult children of your spouse, civil union partner, or domestic partner, and
- Spouses of your adult children.

Family members must be 18 or older.

- If you are a new hire and enroll during your initial benefits enrollment period: You will not have to provide evidence of good health.
- If you enroll at any other time: You must provide evidence of good health acceptable to John Hancock.

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

Premiums for you and your spouse (same or opposite sex)/civil union partner/domestic partner will be deducted from your pay. You will pay for coverage with after-tax dollars; the cost is based on your age when you become insured.

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

If they are disabled on that date, coverage will take effect the first of the month after their disability ends, provided they are still eligible.

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

Family members who visit the website or call to obtain information should provide your name as the Citi employee.

Family members, other than spouses/civil union partners/domestic partners, will be billed directly.

Enrolling in LTC coverage

To enroll in LTC coverage, submit the appropriate application to John Hancock or click on a link from Your Benefits Resources™. Eligible family members must complete an application.

When LTC benefits are payable

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

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

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

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

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

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

Benefits and services covered

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

Choosing a level of coverage

From the six options in the table below, you must choose a daily maximum benefit (DMB) from $115 to $405 a day. The DMB is the most the Plan may pay for all covered services received on any day. Each DMB has a corresponding lifetime maximum benefit (LMB), which is the total amount payable for covered LTC services while you are insured for other than the stay-at-home benefit. Informal care is also subject to a calendar-year maximum.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$290	$345	$405
Alternate care facility DMB	$115	$175	$230	$290	$345	$405
Community-based professional care DMB**	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar year maximum	$862.50	$1,312.50	$1,725	$2,175	$2,587.50	$3,307.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$209,875	$319,375	$419,750	$529,250	$629,625	$739,125
Stay-at-home lifetime maximum	$3,450	$5,250	$6,900	$8,700	$10,350	$12,150

* If you are a Kansas resident, the alternate care facility DMB benefit varies slightly. Call John Hancock at 1-800-222-6814 for details.

** Community-based professional care includes adult day care (Washington state refers to this as adult day health care) and the following services provided in your home: home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

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

Stay-at-home benefit

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

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

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

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

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

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

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

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

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

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

Choosing inflation protection: ABI or future purchase option

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

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

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

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

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

The LMB will be increased in proportion to the increase in the nursing home DMB. An inflation adjustment will not be available if you are issue-age 85 or older or if you have met the benefit eligibility requirements under the policy in the six months prior to the increase effective date or if your coverage is in reduced paid-up status. (If you are a resident of Connecticut, Delaware, Indiana, or Kansas, this provision varies slightly. Call John Hancock at 1-800-222-6814 for details.)

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

Additional features

Return of premium at death benefit

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

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

Waiver of premium

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

Portability

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

Bed reservation benefit

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

Alternate plan of care

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

Restoration of benefits

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

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

Restoration does not apply if coverage is in reduced paid-up status. Your stay-at-home benefit lifetime maximum will not be restored.

Coordination of benefits and exclusions

To prevent duplication of benefits, the Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the Plan when benefits are payable under another plan. (This provision does not apply to residents of Connecticut.)

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

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

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

Tax implications

The Citigroup LTC Insurance Plan is funded through a group policy intended to be a qualified LTC insurance contract under Section 7702B(b) of the Code.

Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your federal income tax return if your total medical expenses, including the allowable portion of your premium, exceed 7.5% of adjusted gross income. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. The benefits you receive under the policy generally are not considered taxable income. Consult your tax adviser if you have any questions or need details.

For more information

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

- Calling the John Hancock Long-Term Care Insurance Department at 1-800-222-6814 or
- Visiting the John Hancock website at **http://groupltc.jhancock.com**. The user name is “groupltc,” and the password is “mybenefit.”

Your family members who call or visit the website should provide your name as the Citi employee.

Administrative Information

This section contains general information about the administration of the Citi Plans, the Plan documents, sponsors, and Claims Administrators.

Contents

Your HIPAA rights 177

Creditable coverage 177

Your special enrollment rights 178

Your right to privacy and information security 178

Notice of HIPAA Privacy Practices 179

HIPAA Certificate of Creditable Coverage 184

Important notices about your Citi prescription drug coverage and Medicare 185

Creditable Coverage Disclosure Notice 185

Non-Creditable Coverage Disclosure Notice 187

ERISA information 189

Recovery provisions 190

Qualified Medical Child Support Orders (QMCSOs) 192

Claims and appeals 192

Medical Care Claims 193

All other benefits claims 196

Regarding appeals 197

Future of the Plans and Plan amendments 198

Plan administration 198

Compliance with law 198

Compliance with Section 125 of the Internal Revenue Code 199

Plan information 200

Claims Administrators 201

Your HIPAA rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

HIPAA restricts the ability of group health plans to exclude coverage for pre-existing conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described under “Your special enrollment rights” on page 178.

Creditable coverage

Under HIPAA, when you and your dependents no longer have Citi medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your dependent(s) will receive a coverage certification when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and upon your request (if the request is made within 24 months following either termination of coverage).

You should keep a copy of the coverage certification(s) you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer’s plan has a preexisting condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Your special enrollment rights

If you decline to enroll in Citi medical coverage for yourself and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citi coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member loses eligibility under another plan or because COBRA coverage has ended.

In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you also may be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you must wait until the next annual enrollment period — or have another qualified status change or special enrollment right — to enroll.

To meet IRS regulations and plan requirements, Citi reserves the right at any time to request written documentation of any dependent'*s eligibility for plan benefits and/or the effective date of the qualifying event.*

Your right to privacy and information security

HIPAA requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the Plans to provide you with a notice of the Plans' legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the Plans' privacy notice for more information. You can obtain a copy of the notice by contacting the Citi Benefits Center.

The Plan Sponsor shall use and disclose individually identifiable health information ("Protected Health Information") as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the "HIPAA Privacy Rule"), only to perform administrative functions on behalf of the Plans. The Plan Sponsor shall not use or disclose such information for any purpose other than as permitted to administer the Plans or as permitted by applicable law.

The Plans shall disclose Protected Health Information to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plan document has been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from any of these plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor shall not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor. The Plan Sponsor shall report to the Plans any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plan Sponsor shall make available Protected Health Information to the Plans for purposes of providing access to individuals' Protected Health Information in accordance with 45 C.F.R. sec. 164.524. The Plan Sponsor shall make available Protected Health Information to these plans for purposes of amending the Plans and shall incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. sec. 164.526. The Plan Sponsor shall make available Protected Health Information and any disclosures thereof to these plans as required to provide an accounting of disclosures in accordance with 45 C.F.R. sec. 164.528.

The Plan Sponsor shall make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plans with the HIPAA Privacy Rules; the Plan Sponsor shall notify the Plans of any such request by the Secretary prior to making such practices, book, and records available. The Plan Sponsor shall, if feasible, return or destroy all Protected Health Information received from the Plans that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosures were made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor shall ensure that only its employees or other persons within the Plan Sponsor's control that participate in administering the Plans shall be given access to Protected Health Information to be disclosed, including those employees or persons who receive Protected Health Information relating to Payment, Health Care Operations (as defined in the HIPAA Privacy Rules) of, or other matters pertaining to the Plans in the ordinary course of the Plan Sponsor's business and perform Plan administration functions. The Plan Sponsor agrees to demonstrate to the satisfaction of the Plans that it has put in place effective procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.

In addition, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic Protected Health Information (as defined in the applicable HIPAA regulations) that it creates, receives, maintains or transmits on behalf of the Plans. The Plan Sponsor will also support the "firewall" described in the last sentence of the preceding paragraph with reasonable and appropriate security measures. The Plan Sponsor shall ensure that any agents or subcontractors to whom the Plan Sponsor supplies Electronic Protected Health information agree to implement reasonable and appropriate security measures to protect such information. The Plan Sponsor shall report any Security Incident (as defined in the applicable HIPAA regulations) of which it becomes aware to the applicable Plan.

Notice of HIPAA Privacy Practices

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

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. All Component Plan have agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms that are not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule, as amended by Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (P.L. 111-5) and regulations promulgated thereunder (ARRA).

For answers to your questions and for additional information

If you have any questions or want additional information about this notice, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed under "Contact information" on page 184.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan. Effective February 17, 2010, the Component Plans are required to limit the use, disclosure, or request for protected health information to the extent practicable to either limited data sets or, if needed, the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Component Plans are obligated to provide to you a copy of this notice setting forth their legal duties and privacy practices regarding your protected health information. Component Plans must abide by the terms of this notice.

Uses and disclosures of Protected Health Information

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

Payment and health care operations

Each Component Plan has the right to use and disclose your protected health information for all activities included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule, as amended by ARRA.

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

Health care operations. Component Plans will use or disclose your protected health information to fulfill Component Plans' business functions. These functions include, but are not limited to, quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, a Component Plan may use or disclose your protected health information (1) to provide information about a disease management program to you; (2) to respond to a customer service inquiry from you; (3) in connection with fraud and abuse detection and compliance programs; or (4) to survey you concerning how effectively such Component Plan is providing services, among other issues.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Other uses and disclosures of your Protected Health Information

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

Contacting you

Each Component Plan (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you, as permitted as part of health care operations, as defined in the HIPAA privacy rules.

As required by law, in the event of an unauthorized disclosure, use, or access of your unsecured protected health information, you will receive written notification.

Your rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request, using the contact information in "Contact information" on page 184.

Right to request a restriction. You have the right to request a restriction on the protected health information that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your protected health information to family members or friends involved in your care or the payment for your care. You may request such a restriction using the contact information as instructed under "Contact information" on page 184.

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

Effective February 17, 2010, a health care provider must comply with your request that protected health information regarding a specific health care item or service not be disclosed to the Component Plan for purposes of payment and health care operations if you have paid for the item or service in full out of pocket.

Right to request confidential communications. If you believe that a disclosure of all or part of your protected health information may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information in "Contact information" on page 184.

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

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

Effective February 17, 2010, you may request an electronic copy of your protected health information if it is maintained in an electronic health record. You may also request that such electronic protected health information be sent to another entity or person. Any charge that is assessed, if any, must be reasonable and based on the Component Plan's cost.

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

Right to request an amendment. You have the right to request an amendment of your protected health information held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your protected health information, your request must be submitted in writing, using the contact information in "Contact information" on page 184, and must set forth a reason(s) to support the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

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

Right to request an accounting. You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information in "Contact information" on page 184. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

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

Right to a paper copy of this notice. You have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically. To obtain such a copy, call the Citi Benefits Center. See "Contact information" on page 184.

Complaints

If you believe a Component Plan has violated your privacy rights or is not fulfilling its obligation under the breach notice rules, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information under "Contact information" on page 184. Component Plans will not penalize you for filing a complaint.

Changes to this notice

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

Effective date

This Notice of HIPAA Privacy Practices became effective April 14, 2003. The Practices were revised effective February 17, 2010.

Contact information

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

Citi Privacy Officer
c/o Corporate Benefits Department
1 Court Square, 46th Floor
Long Island City, NY 11120

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

IF YOU ARE ENROLLED IN ANY OF THESE PLANS:	CALL:
Citigroup Health Benefit Plan **Note:** If you are enrolled in an HMO, call your HMO. Citigroup Dental Benefit Plan Citigroup Vision Benefit Plan Health Care Spending Account Limited Purpose Health Care Spending Account	The Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the “health and welfare benefits” option and speak to a Citi Benefits Center representative. **From outside the United States:** Call the Citi Employee Services North America Service Center at 1-469-220-9600. Press 1 when prompted. From the ConnectOne main menu, choose the “health and welfare benefits” option and speak to a Citi Benefits Center representative. **For TDD users** Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

HIPAA Certificate of Creditable Coverage

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

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

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

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

To request a certificate of creditable coverage, write to the Citi Benefits Center at:

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

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

Important notices about your Citi prescription drug coverage and Medicare

Citi has determined that prescription drug coverage provided through the medical options it offers, other the High Deductible Health Plan-Basic and Premier, is "creditable" under Medicare and that the High Deductible Health Plan-Basic or Premier provides "non-creditable" coverage.

This means that if you become eligible for Medicare in the 12 months beginning January 1, 2010, you are enrolled in a High Deductible Health Plan during that period, and you later elect Medicare Part D prescription drug coverage, you may pay more for it. See more information about Medicare and your choices immediately below.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plans (excluding the High Deductible Health Plan-Basic and Premier)

This notice, required by Medicare to be delivered to Medicare-eligible individuals,* contains information about your current prescription drug coverage with Citi and prescription drug coverage available since January 1, 2006, to people with Medicare.

Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage ceases to be "creditable coverage." You may request another copy of this notice 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.

* Citi is required by law to distribute this notice to both current employees and employees who are enrolled in Citi coverage and who may be Medicare eligible. Generally, you become eligible for Medicare at age 65 or as a result of a disability.

Prescription drug coverage and Medicare

Effective January 1, 2006, prescription drug coverage through Medicare prescription drug plans became available to everyone with Medicare. This coverage is offered by private health insurance companies, not directly by the federal government. *All Medicare prescription drug plans provide at least a "standard" level of coverage set by Medicare.* Some plans also might offer more coverage for a higher monthly premium.

'Creditable coverage'

You have prescription drug coverage through your Citigroup Health Benefit Plan. Citi has determined that your Citi prescription drug coverage is "creditable coverage" because, on average for all plan participants, Citi prescription drug coverage is expected to pay in benefits at least as much as the standard Medicare prescription drug coverage will pay. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Understanding the basics

It is up to you to decide what prescription drug coverage option makes the most financial sense for you and your family given your personal situation. If you are considering the option of joining a Medicare prescription drug plan available in your area, you need to carefully evaluate what that plan has to offer vs. the coverage you have through your Citigroup Health Benefit Plan. Before you decide to join a Medicare prescription drug plan, be sure you understand the implications of doing so,

- You *have* prescription drug coverage under your current Citigroup Health Benefit Plan. Your prescription drug coverage under the Citigroup Health Benefit Plan is considered primary to Medicare, if you are a current employee of Citi. This means that your Citi Plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in the Citigroup Health Benefit Plan, you should consider how Citi coverage would affect the benefits you receive under the Medicare prescription drug plan.

- If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citi coverage is, on average, *at least as good* as standard Medicare prescription drug coverage (this is your "creditable" coverage). As a result, you can keep your current Citi coverage and *not* pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period from November 15-December 31 for coverage effective the first day of the following year.
- If you drop or lose your coverage with Citi and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you lose your prescription drug coverage under the Citigroup Health Benefit Plan, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan.

In addition, if you lose or decide to terminate your coverage under the Citigroup Prescription Drug Program you will be eligible to enroll in a Medicare prescription drug plan at that time under the SEP as well. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Each year Medicare will mail a copy of the handbook to Medicare-eligible individuals. You also may be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- See the "Medicare & You" handbook, which Medicare mails to Medicare-eligible individuals each year.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for the telephone number).
- Call 1-800-MEDICARE (1-800-633-4227); for TDD users, call 1-877-486-2048.

Do you qualify for extra help from Medicare based on your income and resources?

You can obtain Medicare's income level and asset guidelines by calling 1-800-MEDICARE (1-800-633-4227). If you qualify for assistance, visit the Social Security website at **www.socialsecurity.gov** or call 1-800-772-1213 to request an application.

For more information about this notice

Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Note: You will receive this notice each year, before the next period you can join a Medicare prescription drug plan, and if this coverage through Citi changes. You also may request a copy by calling the Citi Benefits Center as instructed immediately above.

Non-Creditable Coverage Disclosure Notice

For employees and former employees enrolled in the High Deductible Health Plan-Basic and Premier

This notice, required by Medicare to be delivered to Medicare-eligible individuals,* contains information about your current prescription drug coverage with Citi and prescription drug coverage available to people with Medicare.

Keep this notice. Please read this notice carefully, and keep it where you can find it. This notice has information about your current prescription drug coverage with Citi and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan.

You may receive this notice at other times, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage becomes "creditable coverage." You may request another copy of this notice 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.

* Citi is required by law to distribute this notice to both current and former employees who are enrolled in Citi coverage and who may be Medicare eligible. Generally, you become eligible for Medicare as a result of reaching age 65 or as a result of a disability.

Prescription drug coverage and Medicare

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you enroll in a Medicare Prescription Drug Plan or a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. *All Medicare drug plans provide at least a standard level of coverage set by Medicare.* Some plans also may offer more coverage for a higher monthly premium.

'Non-creditable coverage'

Citi has determined that the prescription drug coverage offered by the High Deductible Health Plan-Basic and Premier is, on average for all plan participants, *not* expected to pay as much as standard Medicare prescription drug coverage pays and, therefore, is considered "non-creditable coverage." This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan than if you have prescription drug coverage from a Citi High Deductible Health Plan.

Understanding the basics

You have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you enroll in that coverage. Read this notice carefully because it explains your options.

Consider joining a Medicare drug plan

You can keep your coverage from the Citigroup High Deductible Health Plan-Basic or Premier regardless of whether it is as good as a Medicare prescription drug plan. However, because your existing coverage is, on average, not at least as good as standard Medicare prescription drug coverage, you may pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

You can join a Medicare prescription drug plan when you first become eligible for Medicare and each year from November 15-December 31. If you do not enroll in a Medicare drug plan when you are first eligible, you may have to wait to join a Medicare prescription drug plan and may pay a higher premium (a penalty) if you join later.

You may pay that higher premium (a penalty) as long as you have Medicare prescription drug coverage. If you lose your prescription drug coverage under the Citigroup High Deductible Health Plan-Basic or Premier through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan. In addition, if you lose or decide to terminate your coverage under the Citigroup Prescription Drug Program, you will be eligible to join a Medicare prescription drug plan at that time under the SEP.

However, even though the SEP permits you to enroll in a Medicare drug plan, you still may be required to pay a higher premium (a penalty) under the Medicare drug plan because the Citigroup High Deductible Health Plan prescription drug coverage was not creditable coverage.

You need to make a decision

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. If you decide to enroll in a Medicare prescription drug plan and you are an active employee or the family member of an active employee, you may continue your Citi coverage. In this case, the Citigroup Prescription Drug Program will continue to be the primary payer as it had before you enrolled in a Medicare prescription drug plan. Medicare will pay for permitted coverage, as applicable, after Citi pays its benefit. If you waive or drop Citi prescription drug coverage, Medicare will be your only payer.

If you decide to join a Medicare prescription drug plan and drop your Citi prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

You also should know that since your coverage under the Citigroup High Deductible Health Plan-Basic or Premier is not creditable coverage if you keep your coverage with Citi and do not join a Medicare prescription drug plan within 63 continuous days after you are eligible for Medicare prescription drug coverage, you may pay a higher premium (a penalty) to enroll in a Medicare prescription drug plan later.

If you go 63 continuous days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage (creditable coverage), your monthly premium may increase by at least 1% of the base beneficiary premium per month for every month that you did not have creditable coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about Medicare

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. Each year Medicare will mail a copy of the handbook to Medicare-eligible individuals. You also may be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- See the "Medicare & You" handbook, which Medicare mails to Medicare-eligible individuals each year.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for its telephone number).
- Call 1-800-MEDICARE (1-800-633-4227); TDD users, call 1-877-486-2048.

Do you qualify for extra help from Medicare based on your income and resources?

You can obtain Medicare's income level and asset guidelines by calling 1-800-MEDICARE (1-800-633-4227). If you qualify for assistance, visit the Social Security website at **www.socialsecurity.gov** or call 1-800-772-1213 to request an application.

For more information about this notice

Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Note: You will receive this notice each year. You also will receive it before the next period you can join a Medicare prescription drug plan and if this coverage through Citi changes. You also may request a copy through the Citi Benefits Center.

ERISA information

As a participant in Citi Health and Welfare Plans subject to ERISA (which excludes DCSA and TRIP), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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

Upon written request to the Plan Administrator, you may obtain copies of documents governing the operation of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500), and the current summary plan description. The Plan Administrator will mail these documents to your home free of charge. You also may receive a copy of the Plan's annual financial report. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

If there is a loss of coverage under the Plan as a result of a qualifying event, you may continue health care coverage for yourself, spouse (whether same or opposite sex)/civil union partner/domestic partner, or eligible dependents. You or your dependents may have to pay for such coverage. Review this SPD and all other documents governing the Plans for the rules governing your continuation coverage rights.

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

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

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

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

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plans review and reconsider your claim and provide you with copies of documents relating to the decision without charge. For more information see the "Claims and appeals" section beginning on page 192.

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

If your claim for benefits is denied or ignored, in full or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If you believe the fiduciaries are misusing their authority under the Plan or if you believe you are being discriminated against for asserting your rights, you may request assistance from the U.S. Department of Labor or file a suit in federal court, subject to limitations imposed by Plan rules.

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

Answers to your questions

If you have questions about the Plans, contact the Plan Administrator listed under "Plan administration" on page 198.

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

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

Recovery provisions

Refund of overpayments

Whenever payments have been made by any of the Plans for covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), the covered person(s) must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In the case of a recovery from a source other than the Plans, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plans that should have been made under another group plan. In that case, the Plans may recover the payment from one or more of the following: any other insurance company, any other organization, or any person to or for whom payment was made.

The Plans may, at their option, recover the Overpayment by reducing or offsetting against any future benefits payable to the covered person or his/her survivors; stopping future benefit payments that would otherwise be due under the Plans (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the covered person.

The Plan Administrator of the Disability Plan reserves the right to recover funds related to disability benefits for any Overpayment when a covered person receives state benefits including Workers' Compensation and Social Security benefits.

Reimbursement

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

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

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

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

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

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

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

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

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

Subrogation

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

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

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

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Plan under this section. Further, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

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

Qualified Medical Child Support Orders (QMCSOs)

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Medical, Dental, or Vision Plan or the Health Care Spending Accounts who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Medical, Dental, or Vision Plan, or the Health Care Spending Accounts.

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

To receive, at no cost, a detailed description of the procedures for a QMCSO, or if you have a question about filing a QMCSO, call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the “health and welfare benefits” options.

You can file your QMCSO by mailing it to:

Citi Benefits Center
Attention: Qualified Order Team
P.O. Box 1433
Lincolnshire, IL 60069-1433
Phone: 1-800-881-3938
Fax: 1-847-883-9313

Claims and appeals

To receive benefits from most of the Citi benefit plans, you will need to file a claim.

Medical	
• For all plans other than HMOs	Use one of the following forms available on **Citi.net** to file a claim for a covered out-of-network expense: • 301 — Aetna Claim Form (for ChoicePlan 500, HDHP Basic & Premier participants). • 303 — UnitedHealthcare Claim Form (for Hawaii Plan participants) • 322 — BlueCross BlueShield (for ChoicePlan 500 participants). • 310 — Express Scripts Retail Pharmacy–prescription drug program related to all non-HMO plans • 311 — Express Scripts Home Delivery–prescription drug program related to all non-HMO plans
• HMO participants	• Call your HMO for any claim-filing information.
Dental	
• MetLife Preferred Dentist Program (PDP)	• Use Form 304 — MetLife Dental Claim form available on **www.Citi.net**.
• CIGNA Dental Care DHMO	• There are no claim forms to file under this plan.
Vision	• Call Davis Vision at 1-800-999-5431 or visit **www.davisvision.com**.
Employee Assistance Program	• Call Harris Rothenberg at 1-800-952-1245 or visit **www.harrisrothenberg.com** (Benefit Service Claims Only)
General Purpose Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	• If you do not use a Your Spending Account (YSA) card for an eligible Health Care Spending Account purchase, you can file a claim by using Form 316 - 2010 Health Care Spending Account/Limited Purpose Health Care Spending Account Claim Form. You may obtain forms via the Web at **http://www.citigroup.net/human_resources/forms/benefits_forms.html** or submit a claim online via the YSA website. You may access the YSA website through a link on the Your Benefits Resources™ (YBR) website. To access YBR, you can go: – Through Total Comp @ Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet; or – Directly to **http://resources.hewitt.com/citigroup** using your YBR user ID and password.

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

- Medical, dental, and vision claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA/LPSA claims must be filed by June 30 of the calendar year following the plan year in which the expense was incurred.

To file a claim or appeal, you must use the designated form in accordance with Plan procedures. By participating in the Plans, you and your beneficiaries agree that you cannot commence a legal action against the Plans more than one year after your final appeal has been denied, unless an insurance contract made available under the Plan provides for a different limitation. No legal action can be brought to recover benefits under any of the Plans until the appeal rights described below have been exercised, and the Plan benefits requested in such appeal have been denied.

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plan subject to ERISA, which excludes DCSA and TRIP, or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrators, as applicable. For more information about the Plan Administrator and Claims Administrators, see "Plan administration" on page 198 and the list of Claims Administrators under "Claims Administrators" on page 201.

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

ERISA provides for different timetables and claims procedures that may vary by type of benefit. Each of the medical benefits (including dental and vision benefits), disability benefits, and all other types of benefits has a different timetable and claims and appeals procedures. General information about the claims and appeals procedures is set forth below.

Detailed procedures governing claims for benefits, applicable time limits, and remedies available under the Citi medical, dental, vision, HCSA, LPSA, and disability Plans for the redress of claims that are denied are included in the Plan documents available at **www.benefitsbookonline.com**.

If you do not have access to the Citi intranet or the Internet, you can request a copy at no cost to you by speaking with a Citi Benefits Center representative through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.

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

Medical Care Claims

There are four categories of claims for medical benefits, each with somewhat different claim and appeal rules. The primary difference is the time frame within which claims and appeals must be determined.

1. **Preservice claim.** A claim is a preservice claim if the receipt of the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under any Plan that require approval in advance are specifically noted in this book or in the Plan document as being subject to preservice authorization.
2. **Urgent care claim.** A claim involving urgent care is any preservice claim for medical care or treatment to which the application of the time periods that otherwise apply to preservice claims could seriously jeopardize the claimant's life or health or ability to regain maximum function or would — in the opinion of a physician with knowledge of the claimant's medical condition — subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

   On receipt of a preservice claim, the Claims Administrator will determine whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim shall be treated as an urgent care claim.

3. **Post-service claim.** A post-service claim is any claim for a benefit under this Plan that is not a preservice claim or an urgent care claim.
4. **Concurrent care claim.** A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding initial medical benefit claims

A post-service claim must be filed within 90 days following receipt of the medical service, treatment, or product to which the claim relates unless (a) it was not reasonably possible to file the claim within such time and (b) the claim is filed as soon as possible and in no event (except in the case of legal incapacity of the claimant) later than 12 months after the date of receipt of the service, treatment, or product to which the claim relates.

These claims procedures do not apply to any request for benefits that is not made in accordance with these procedures or other procedures prescribed by the Claims Administrator except that, (a) in the case of an incorrectly filed preservice claim, the claimant shall be notified as soon as possible but no later than five days following the receipt of the incorrectly filed claim, and (b) in the case of an incorrectly filed urgent care claim, you will be notified as soon as possible but no later than 24 hours following receipt of the incorrectly filed claim.

The Claims Administrator will decide an initial preservice claim within a reasonable time appropriate to the medical circumstances but no later than 15 days after receipt of the claim.

The Claims Administrator will decide an initial urgent care claim as soon as possible, taking into account the medical urgencies but no later than 72 hours after receipt of the claim.

However, if a claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after the receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable time frames for preservice, urgent care, or post-service claims.

A decision by the Claims Administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant, as explained below. Notification to the claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

An initial post-service claim shall be decided within a reasonable time but no later than 30 days after the receipt of the claim.

Despite the specified time frames, nothing prevents you from voluntarily agreeing to extend the above time frames. In addition, if the Claims Administrator is not able to decide a preservice or post-service claim within the above time frames due to matters beyond its control, one 15-day extension of the applicable time frame is permitted, provided that you are notified in writing prior to the expiration of the initial time frame applicable to the claim. The extension notice shall include a description of the matter beyond the Plan's control that justifies the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If an urgent care claim is incomplete, the Claims Administrator shall notify you as soon as possible but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally, unless you request a written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Claims Administrator shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information or (b) the end of the period of time provided to submit the specified information.

If a preservice or post-service claim is incomplete, the Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a time frame, no less than

45 days, in which the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of initial benefit decision by Plan

You will receive written notification of an adverse decision on a claim, and it will include the following:

- The specific reasons for the denial;
- The specific reference to the Plan documentation that supports these reasons;
- The additional information you must provide to perfect your claim and the reasons why that information is necessary; The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);
- If the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Written notification of the decision on a preservice or urgent care claim will be provided to you whether or not the decision is adverse. Notification of an adverse decision on an urgent care claim may be provided orally, but written notification will be furnished no later than three days after the oral notice.

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Medical Care Claims” on page 193) must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate.

Failure to comply with this important deadline may cause you to forfeit any rights to any further review of an adverse decision under these procedures or in a court of law.

The appeal shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt of the appeal.

The appeal of an urgent care claim shall be decided as soon as possible, taking into account the medical urgency but no later than 72 hours after receipt of the appeal.

The appeal of a post-service claim shall be decided within a reasonable period but no later than 60 days after receipt of the appeal.

The appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Medical Care Claims” on page 193) shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend a concurrent care decision shall be decided in the appeal time frame for a preservice, urgent care, or post-service claim described above, as appropriate to the request.

Notice of benefit determination on appeal

You will receive written or electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan and a statement of your right to bring an action under Section 502(a) of ERISA;
5. If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge on request; and
6. If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

All other benefits claims

If your application to enroll in any of the health and welfare Plans subject to ERISA is denied, you may file a claim with the Plans Administration Committee of Citigroup Inc. (the "Committee"). You also may file an appeal if the Committee denies your claim.

To file an enrollment-related claim and for information on the claim review process, use the Health and Disability Benefits Eligibility Claims and Appeals Form available to you at no cost 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. Follow the instructions on the form and return the form to the Plans Administration Committee at the address on the form.

In addition, if you file a claim for benefits under the Citigroup Disability, Life Insurance, Business Travel Accident/Medical, GUL/Supplemental AD&D, or the Long-Term Care Insurance Plans, your claim will be administered in accordance with the following timetable.

Notice of adverse benefit determinations

If your claim is denied, you will receive a written or an electronic notice within 90 days after receipt of your claim (180 days if special circumstances apply and you are notified of the extension in writing within the initial 90-day period and informed of the anticipated benefit determination date). If your claim is for disability benefits, you will receive a written or an electronic notice within 45 days after receipt of your claim (105 days if special circumstances apply and you are notified of the extension in writing within the initial 45-day period and informed of the anticipated benefit determination date). The explanation will include the following:

1. The specific reasons for the denial;
2. The specific reference to the Plan documentation that supports these reasons;
3. The additional information you must provide to perfect your claim and the reasons why that information is necessary;
4. The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review; and
5. A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request).

Appeals

You have a right to appeal a denied claim by filing a written request for review of your claim with the Claims Administrator within 60 days after receipt of the notice informing you that your claim has been denied. In the case of a disability claim, you have 180 days following receipt of the notification in which to appeal the decision.

The Claims Administrator will conduct a full and fair review of your claim and appeal. You or your representative may review Plan documents and submit written comments with your appeal. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim.

The Claims Administrator's review will take into account all comments, documents, and other claim-related information that you submit regardless of whether that information was submitted or considered in the initial benefit determination.

The Claims Administrator will reach a determination regarding your appeal 60 days after its receipt (120 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 60 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

In the case of a claim for disability benefits, the Claims Administrator will reach a determination regarding your appeal 45 days after its receipt (90 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 45 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of benefit determination on appeal

You will receive written or electronic notice of the benefit determination upon review. In the event your claim is denied on appeal, the notice will provide:

1. The specific reason or reasons for the denial of the appeal;
2. Reference to the specific Plan provisions on which the benefit determination is based;
3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
4. A statement describing any voluntary appeal procedures offered by the Plan, and a statement of your right to bring an action under Section 502(a) of ERISA; and
5. If an internal rule or guideline was relied on in making the adverse determination, either the specific rule or guideline, or a statement that such a rule or guideline was relied on in making the adverse determination and that a copy of such rule or guideline will be provided free of charge upon request.

In the event that your appeal is denied, you have the right to bring a legal action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, regarding the Plans within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to begin suit is specified in an insurance contract forming part of the Plans or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

You and the Plans may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency, as applicable. Generally, the determination reached by the Plans is final.

Regarding appeals

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Claims Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures. However, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plans. Notwithstanding any provision of the Plan to the contrary, you must file any lawsuit related to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two

year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan, that period will apply to suits against the insurer.

Future of the Plans and Plan amendments

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

Citigroup Inc. (or its affiliate, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy, or program in whole or in part, at any time, for any reason, without prior notice. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements.

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

Plan administration

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

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

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

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

The delegation by the Plan Administrator may (but is not required to) be in writing.

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

Compliance with law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA (Uniformed Services Employment and Re-employment Rights Act), HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, and the Women's Health and Cancer Rights Act of 1998.

Compliance with Section 125 of the Internal Revenue Code

This plan document describing the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, and the Citigroup Vision Benefit Plan (as well as other plans) and documents governing participant elections generally are, when read together, intended to comply with the requirements of Section 125 of the Internal Revenue Code of 1986, as amended, and constitute a cafeteria plan. All such documents are incorporated by reference to constitute a single plan, in accordance with applicable Treasury regulations.

As stated previously in this document, all participants are entitled to make their benefit elections under the foregoing Plans through salary reduction arrangements so that the participant's premium payments or health care spending account contributions can be made on a pretax basis.

This plan document describes the benefits available, authorizes employees to enter into salary reduction arrangements to pay their portion of the health care premiums on a pretax basis and authorizes employees to contribute amounts under the Health Care Spending Account and Limited Purpose Health Care Account on a pre-tax basis with respect to subsequent expenses that will be incurred and later reimbursed.

Changes in such elections are available only in limited circumstances set forth in the Plan document. The change in coverage must be consistent with the change in status. For example, if a dependent is added, the coverage should increase (not decrease). In addition to the foregoing, the Plans permit election changes based on the special enrollment rights under HIPAA.

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

Plan information

Plan sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830
Employer identification number	52-1568099
Participating Employers	Citigroup Inc. and any of its [U.S.] subsidiaries in which at least an 80% interest is owned.
Plan Administrator	Plans Administration Committee of Citigroup Inc. 1 Court Square, 46th Floor Long Island City, NY 11120 1-800-881-3938 (ConnectOne). From the ConnectOne main menu, choose the "health and welfare benefits" option and then speak to a Citi Benefits Center representative. From outside the United States, call the Citi Employee Services North America Service Center at 1-469-220-9600. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.
Plan Names And Numbers	
Medical Plan: Self-funded ChoicePlan 500, High Deductible Health Plan-Basic and Premier, Hawaii Health Plan, Oxford Health Plans PPO, and HMOs, including prescription drugs; medical clinics	Citigroup Health Benefit Plan, Plan #508
Dental Plan	Citigroup Dental Benefit Plan, Plan #505
Vision Plan	Citigroup Vision Benefit Plan, Plan #533
Employee Assistance Program	Citigroup Employee Assistance Program, Plan #521
Health Care Spending Account and Limited Purpose Health Care Spending Account	Citigroup Flexible Benefits Plan, Plan #512
Dependent Day Care Spending Account	Not applicable (DCSA is not an ERISA plan)
Transportation Reimbursement Incentive Program	Not applicable (TRIP is not an ERISA plan)
Basic Life insurance/AD&D and GUL/Supplemental AD&D Business Travel Accident insurance Long-Term Care insurance	Citigroup Life Insurance Benefits Plan, Plan #506 Citigroup Business Travel Accident Plan, Plan #510 Citigroup Long-Term Care Insurance Plan, Plan #535
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan, Plan #530
Agent for service of legal process	Citigroup Inc. General Counsel, HR 1 Court Square, 9th Floor Long Island City, NY 11120
Plan year	January 1-December 31

Funding	
Medical Plan Dental Plan Vision Plan Employee Assistance Program Health Care Spending Account (HCSA) Limited Purpose Health Care Spending Account (LPSA) Basic Life/AD&D insurance GUL/Supplemental AD&D insurance Business Travel Accident insurance Disability Plan	The Medical Plan and Dental Plan are funded through insurance contracts, the general assets of Citigroup, or a trust qualified under Section 501(c)(9) of the Code on behalf of the Plans. The Vision Plan is funded through an insurance contract. The medical spending accounts and the Employee Assistance Program are funded from the general assets of Citigroup. The cost of medical and dental coverage is shared by Citigroup and the participant. The cost of the Vision Plan and medical spending accounts is provided by employee contributions. Citigroup pays for the Employee Assistance Program. Basic Life/AD&D, GUL/Supplemental AD&D, and Business Travel Accident insurance are fully insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life/AD&D and Business Travel Accident coverage is provided through employer contributions; GUL/Supplemental AD&D is provided through employee contributions. STD benefits are paid from the general assets of the Company or a trust qualified under Section 501(c)(9) of the Code. STD coverage is provided by Citigroup; no employee contributions are required. LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
Long-Term Care insurance (LTC)	LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions. Any refund, rebate, dividend adjustment, or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses.
On-site medical clinics	On-site medical clinics are funded from the general assets of Citigroup Inc.
Type of administration	The Plans are administered by the Plans Administration Committee. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.

Claims Administrators

Each of the Claims Administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of its respective benefit Plan, namely, those provisions of the Plan documents that apply to the participant and are administered by that particular Claims Administrator. Since TRIP and DCSA are not subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.

MEDICAL PLAN AND PRESCRIPTION DRUG COVERAGE	
ChoicePlan 500	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098 (Empire BlueCross BlueShield is a trademark of Empire HealthChoice Assurance, Inc., a licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. Empire does not underwrite or assume any financial risk for claims liability.)
High Deductible Health Plan - Basic and Premier	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862
Oxford Health Plans PPO	Oxford Health Plans Attn: Claims Department P.O. Box 7082 Bridgeport, CT 06601-7082 1-800-760-4566

Administrative Information

Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
For fully insured HMOs	Call the HMO directly at the telephone number on your ID card.
Prescription Drug Program	
Paper claims address	Express Scripts Pharmacy P.O. Box 66583 St. Louis, MO 63166
Home delivery service	Express Scripts Pharmacy Home Delivery Service P.O. Box 510 Bensalem, PA 19020 0510
DENTAL PLAN	
MetLife Preferred Dentist Program	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso TX 79998-1282 1-888-832-2576 To submit an appeal: Metropolitan Life Insurance Co. P.O. Box 14093 Lexington, KY 40512-4093
CIGNA Dental HMO	CIGNA Dental HMO / Member Services 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323 1-800-244-6224
VISION	
Vision Plan	Davis Vision 159 Express St. Plainview, NY 11803 1-516-932-9500 1-800-DAVIS-2-U
SPENDING ACCOUNTS	
Health Care Spending Account Limited Purpose Health Care Spending Account Dependent Day Care Spending Account Transportation Reimbursement Incentive Program	Citi Benefits Center 2300 Discovery Drive P.O. Box 785004 Orlando, FL, 32878-5004 Call the Citi Benefits Center through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the “health and welfare benefits” option.

OTHER INSURANCE	
Basic Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 1-800-638-6420
Group Universal Life	Metropolitan Life Insurance Co. Group Plan # 96731 P.O. Box 3016 Utica, NY 13504 1-800-523-2894
Accidental Death and Dismemberment and Supplemental AD&D	Life Insurance Company of North America (CIGNA) 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000
Business Travel Accident/Medical	ACE American Insurance Company Accident & Health Claims 1 Beaver Valley Road, P.O. Box 15417 Wilmington, DE 19850 1-800-336-0627
Short-Term Disability Long-Term Disability	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 1-888-830-7380
Long-Term Care	John Hancock Life Insurance Co. Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 1-800-222-6814
Agent for Service of Legal Process	Citigroup Inc. General Counsel HR 1 Court Square, 9th Floor Long Island City, NY 11120
Plan Year (for all Plans)	January 1 — December 31
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators.

Glossary

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

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

Custodial care: Services and supplies furnished to a person mainly to help him or her in the activities of daily life. These services include board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard:

- To whom they are prescribed; or
- To whom they are recommended; or
- Who performs them.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost.

The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they are afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status. See “Notice of HIPAA Privacy Practices” in the *Administrative Information* section.

Medically necessary: A service or supply is considered medically necessary if it is a generally accepted health care practice and is required to treat a condition, as determined by the Claims Administrator. No benefit will be paid for services that are not considered medically necessary.

Non-occupational disease: A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be deemed non-occupational regardless of the cause if proof is furnished that the person:

- Is covered under any type of Workers’ Compensation law and
- Is not covered for that disease under such law.

Non-occupational injury: A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit or
- Result in any way from an injury that does.

Notification: A requirement that a participant calls his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. Notification helps ensure that the participant obtains the most appropriate care for his or her condition in the most appropriate setting. Call your Plan for more information.

Out-of-pocket maximum: Total payments (deductibles and coinsurance) toward eligible expenses that a covered person pays for himself or herself and/or dependents as defined by the contract.

Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of reasonable and customary (R&C) charges. If the expenses incurred are higher than the R&C amount, the individual receiving the service is responsible for paying the difference even if the out-of-pocket maximum has been reached.

Precertification: A requirement that a participant calls his or her health Plan before seeking certain treatment. The Plan will:

- Help the participant and his/her health care provider determine the best course of treatment based on the diagnosis and acceptable medical practice, and
- Determine whether certain covered services and supplies are medically necessary.

No benefit will be paid for services that are not considered medically necessary.

Pre-existing condition: An injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — a participant 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.

Preventive care: Routine care examinations based on guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams), routine cancer screenings, and immunizations. See "Preventive care" in the *Health Care Benefits* section.

Reasonable and customary (R&C) charge: Any charge that, for services rendered by or on behalf of a non-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

As to all other charges, an amount measured and determined by the Claims Administrator by comparing the actual charge for the service or supply with the prevailing charges made for it. The Claims Administrator determines the prevailing charge by taking into account all pertinent factors including:

- The complexity of the service;
- The range of services provided; and
- The prevailing charge level in the geographic area where the provider is located and other geographic areas having similar medical cost experience.

Wellness services: Charges for routine care examinations based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include, but are not limited to, routine physical exams (including well-woman and well-child exams), cancer screenings, and immunizations.

Additional medical coverage definitions

The following definitions apply to benefits provided under the Medical Plan, unless clearly indicated otherwise.

Accredited school or college: An accredited secondary school, junior college, college, or university or a state or federally accredited trade or vocational school.

Ambulatory surgical center: A specialized facility established, equipped, operated, and staffed primarily to perform surgical procedures and that fully meets one of the following two tests:

- It is licensed as an ambulatory surgical center by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located or
- Where licensing is not required, it meets all of the following requirements:
  - It is operated under the supervision of a licensed doctor of medicine (MD) or doctor of osteopathy (DO) who devotes full time to supervision and permits a surgical procedure to be performed only by a duly qualified physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one hospital in the area;
  - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic and that the anesthesiologist or anesthetist remain present throughout the surgical procedure;
  - It provides at least one operating room and at least one post-anesthesia recovery room;
  - It is equipped to perform diagnostic X-ray and laboratory examinations or has arranged to obtain these services;
  - It has trained personnel and necessary equipment to handle emergency situations;
  - It has immediate access to a blood bank or blood supplies;
  - It provides the full-time services of one or more registered nurses (RN) for patient care in the operating rooms and in the post-anesthesia recovery room; and
  - It maintains an adequate medical record for each patient, the record to contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report, and a discharge summary.

An ambulatory surgical center that is part of a hospital, as defined herein, will be considered an ambulatory surgical center for the purposes of the Plan.

Birth center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and that fully meets one of the following two tests:

- It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located and
- It meets all of the following requirements:
  - It is operated and equipped in accordance with any applicable state law;
  - It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria, and specific gravity;
  - It has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
  - It is operated under the full-time supervision of a licensed doctor of medicine (MD), doctor of osteopathy (DO), or registered nurse (RN);
  - It maintains a written agreement with at least one hospital in the area for immediate acceptance of patients who develop complications;
  - It maintains an adequate medical record for each patient, the record to contain prenatal history, prenatal examination, any laboratory or diagnostic tests, and a postpartum summary; and
  - It is expected to discharge or transfer patients within 24 hours following delivery unless medically necessary.

A birth center that is part of a hospital, as defined herein, will be considered a birth center for the purposes of the Plan.

Brand-name drug: A drug that is under patent by its original innovator or marketer.

Calendar year: January 1 through December 31 of the same year. For new enrollees, the calendar year is the effective date of their enrollment through December 31 of the same year, unless otherwise provided in the open enrollment materials.

Chiropractic care: Skeletal adjustments, manipulation, or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment, or subluxation of, or in, the vertebral column. The following are not considered to be chiropractic care: chiropractic appliances, services related to the diagnosis and treatment of jaw joint problems such as temporomandibular joint (TMJ) syndrome or craniomandibular disorders or services for treatment of strictly non-neuromusculoskeletal disorders.

Claims Administrator: Aetna, Empire BlueCross BlueShield, Oxford PPO Health Plans, UnitedHealthcare, and Express Scripts and any other party designated as a claims fiduciary pursuant to a contractual relationship and as authorized by the Plans Administration Committee of Citigroup Inc. The Claims Administrator does not insure the benefits described in this document.

Comprehensive outpatient rehabilitation facility: A facility that is primarily engaged in providing diagnostic, therapeutic, and restorative services to outpatients for the rehabilitation of injured or sick persons and that fully meets one of the following two tests:

- It is approved by Medicare as a comprehensive outpatient rehabilitation facility or
- It meets all of the following tests:
  - It provides at least the following comprehensive outpatient rehabilitation services:
    - Services of physicians who are available at the facility on a full- or part-time basis;
    - Physical therapy; and
    - Social or psychological services;
  - It has policies established by a group of professional personnel (associated with the facility), including one or more physicians to govern the comprehensive outpatient rehabilitation services it furnishes and provides for the carrying out of such policies by a full- or part-time physician;
  - It has a requirement that every patient must be under the care of a physician; and
  - It is established and operates in accordance with the applicable licensing and other laws.

Glossary

Cosmetic surgery: Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns, or disfigurements and teeth whitening.

Covered family members or covered person: The employee and the employee's legal spouse (whether same or opposite sex) and/or dependent children, or qualified domestic partner/civil union partner who are covered under the Plan.

Designated transplant facility: A facility designated by the Claims Administrator to render medically necessary covered services and supplies for qualified procedures under the Plan.

Emergency care: Medical care and treatment provided after the sudden onset of a medical condition manifesting itself by acute symptoms, including severe pain. The symptoms must be severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following:

- The patient's health would be placed in serious jeopardy;
- Bodily function would be seriously impaired; and
- There would be serious dysfunction of a bodily organ or part.

Emergency care includes immediate mental health and chemical dependency treatment when the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

Experimental, investigational, or unproven services: Medical, surgical, diagnostic, psychiatric, substance abuse, or other health care services, technologies, supplies, treatments, procedures, drug therapies, or devices that, at the time the Health Plan makes a determination regarding coverage in a particular case, are determined to be:

- Not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- Subject to review and approval by any institutional review board for the proposed use;
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2, or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; and
- Not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

The Claims Administrator, in its judgment, may deem an experimental, investigational, or unproven service covered under the Plan for treating a life-threatening sickness or condition if it is determined by the Claims Administrator that the experimental, investigational, or unproven service at the time of the determination:

- Is proved to be safe with promising efficacy;
- Is provided in a clinically controlled research setting; and
- Uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For purposes of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

Fiduciary: A person who exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan. The "named fiduciary" for the Plan is the Plans Administration Committee of Citigroup Inc., except to the extent fiduciary authority has been delegated by this document or otherwise to Claims Administrators or others.

Generic drug: Equivalent medications that contains the same active ingredient and are subject to the same rigid FDA standards for quality, strength, and purity as their brand-name equivalents. Generic drugs are less expensive than brand-name drugs.

Home health care agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

- It is approved under Medicare;

- It is established and operated in accordance with the applicable licensing and other laws; or
- It meets all of the following tests:
  - Its primary purpose is to provide a home health care delivery system bringing supportive services to the home;
  - It has a full-time administrator;
  - It maintains written records of services provided to the patient;
  - Its staff includes at least one registered nurse (RN) or it has nursing care by a registered nurse (RN) available; and
  - Its employees are bonded, and it maintains malpractice insurance.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual. Room and board may be provided. The agency must meet one of the following three tests:

- It is approved by Medicare as a hospice;
- It is licensed in accordance with any applicable state laws; or
- It meets the following criteria:
  - It provides 24/7 service;
  - It is under the direct supervision of a duly qualified physician;
  - It has a nurse coordinator who is a registered nurse with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients;
  - The main purpose of the agency is to provide hospice services;
  - It has a full-time administrator;
  - It maintains written records of services given to the patient; and
  - It maintains malpractice insurance coverage.

A hospice that is part of a hospital will be considered a hospice for the purposes of the Plan.

Hospital: An institution engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and fully meets one of the following three tests:

- It is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- It is approved by Medicare as a hospital; or
- It meets all of the following tests:
  - It maintains, on the premises, diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of duly qualified physicians;
  - It continuously provides, on the premises, 24/7 nursing service by or under the supervision of registered graduate nurses; and
  - It is operated continuously with organized facilities for operative surgery on the premises.

Injury: An accidental physical injury to the body caused by unexpected external means.

Intensive care unit: A separate, clearly designated service area maintained within a hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has facilities for special nursing care not available in regular rooms and wards of the hospital, special life-saving equipment that is immediately available at all times, at least two beds for the accommodation of the critically ill, and at least one registered nurse (RN) in continuous and constant attendance 24/7.

Licensed counselor: A person who specializes in mental health and chemical dependency treatment and is licensed as a Licensed Clinical Social Worker (LCSW) by the appropriate authority.

Lifetime: A word appearing in the Plan in reference to benefit maximums and limitations. Lifetime is understood to mean the period of time in which a participant and his or her eligible dependent are covered under the Plan. Under no circumstances does lifetime mean during the lifetime of the covered individual.

Medically necessary or medical necessity: Health care services and supplies that are determined by the Claims Administrator to be medically appropriate and:

- Necessary to meet the basic health needs of the covered person;
- Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the service or supply;
- Consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Health Plan;
- Consistent with the diagnosis of the condition;
- Required for reasons other than the convenience of the covered person or his or her physician;
- Must be provided by a physician, hospital, or other covered provider under the Health Plan;
- With regard to an inpatient, it must mean the patient's illness or injury requires that the service or supply cannot be safely provided to that person on an outpatient basis;
- It must not be primarily scholastic, vocational training, educational or developmental in nature, or experimental or investigational;
- Demonstrated through prevailing peer-reviewed medical literature to be either:
  - Safe and effective for treating or diagnosing the condition or sickness for which their use is proposed or
  - Safe with promising efficacy:
    - For treating a life-threatening sickness or condition;
    - In a clinically controlled research setting; and
    - Using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

(For the purpose of this definition, the term "life-threatening" is used to describe sicknesses or conditions that are more likely than not to cause death within one year of the date of the request for treatment.)

The fact that a physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness, mental illness, or pregnancy does not mean that it is medically necessary as defined above. The definition of medically necessary used in this summary relates only to coverage and differs from the way in which a physician engaged in the practice of medicine may define medically necessary. The Plans Administration Committee may delegate the discretionary authority to determine medical necessity under the Health Plans. No benefit will be paid for services that are not considered medically necessary.

Medicare: The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental health and chemical dependency treatment: Treatment for both of the following:

- Any sickness identified in the current edition of *The Diagnostic and Statistical Manual of Mental Disorders* (DSM), including a psychological and/or physiological dependence or addiction to alcohol or psychoactive drugs or medications, regardless of any underlying physical or organic cause and
- Any sickness for which the treatment is primarily the use of psychotherapy or other psychotherapeutic methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a sickness identified in the DSM, are considered mental health and chemical dependency treatment, except in the case of multiple diagnoses.

If there are multiple diagnoses, only the treatment for the sickness that is identified in the DSM is considered mental health and chemical dependency treatment.

Detoxification services given prior to and independent of a course of psychotherapy or substance abuse treatment is not considered mental health and chemical dependency treatment.

Prescription drugs are not considered mental health and chemical dependency treatment.

Morbid obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent body mass index (BMI) tables for a person of the same height, age, and mobility as the covered person. For **Aetna and Empire plans**, the BMI is greater than 40 kilograms per meter squared or equal to or greater than 35 kilograms per meter squared with a co-morbid medical condition, including hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

Network pharmacy: Registered and licensed pharmacies, including mail-order pharmacies that participate in the network.

Network provider: A provider that participates in the health plan network in which you enrolled.

Non-preferred brand-name drug: A brand-name drug that is not a formulary drug. See the definition of preferred brand-name drug.

Nurse-midwife: A person licensed or certified to practice as a nurse-midwife and who fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse and
- A person who has completed a program approved by the state for the preparation of nurse-midwives.

Nurse-practitioner: A person who is licensed or certified to practice as a nurse-practitioner and fulfills both of these requirements:

- A person licensed by a board of nursing as a registered nurse and
- A person who has completed a program approved by the state for the preparation of nurse-practitioners.

Occupational therapy: Services that improve the patient's ability to perform tasks required for independent functioning when the function has been temporarily lost and can be restored.

Other services and supplies: Services and supplies furnished to the individual and required for treatment, other than the professional services of any physician and any private-duty or special nursing services (including intensive nursing care by whatever name called).

Out-of-network hospital: A hospital (as defined) that does not participate in the health plan network in which you enrolled.

Out-of-network pharmacy: A pharmacy other than an Express Scripts network pharmacy.

Out-of-network provider: A provider that does not participate in the health plan network in which you enrolled.

Outpatient care: Treatment including services, supplies, and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Physical therapy: Services that are designed to restore an individual to a level of function present prior to an illness or accidental injury.

Physician: A legally qualified and licensed:

- Doctor of Medicine (MD);
- Doctor of Chiropody (DPM; DSC);
- Doctor of Chiropractic (DC);
- Doctor of Dental Surgery (DDS);
- Doctor of Medical Dentistry (DMD);
- Doctor of Osteopathy (DO); or
- Doctor of Podiatry (DPM).

Care provided by Christian Science practitioners is covered as an out-of-network benefit under ChoicePlan 500.

Plan: The Citigroup Health Benefit Plan, as amended from time to time. For ERISA reporting purposes, the Plan number is Plan 508.

Plan Administrator: The Plans Administration Committee of Citigroup Inc.

Plan year: January 1 – December 31.

Preadmission tests: Tests performed on a covered person in a hospital before confinement as a resident inpatient provided the tests meet all of the following requirements:

- The tests are related to the performance of scheduled surgery;
- The tests have been ordered by a physician after a condition requiring surgery has been diagnosed and hospital admission for surgery has been requested by the physician and confirmed by the hospital; and
- The covered person is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the covered person's condition that precludes the surgery.

Preferred brand-name drug: A drug that is prescribed from a list of medications preferred for its clinical effectiveness and opportunity to help contain health care costs. Preferred drugs are part of an incentive program to help control the costs of care and are frequently called formulary drugs.

Prescription drugs: Any drugs that cannot be dispensed without a doctor's prescription. The following will be considered prescription drugs:

- Federal legend drugs. This is any medicinal substance that the federal Food, Drug, and Cosmetic Act requires to be labeled "Caution — federal law prohibits dispensing without prescription";
- Drugs that require a prescription under state law but not under federal law;
- Compound drugs having more than one ingredient, and at least one of the ingredients has to be a federal legend drug or a drug that requires a prescription under state law;
- Injectable insulin; and
- Needles and syringes.

Primary care physician (PCP): A physician in general practice or who specializes in pediatrics, family practice, or internal medicine who has agreed with the Claims Administrator to act as the entry point to the health care delivery system and may be the coordinator of member care. The PCP is not an agent or employee of the Claims Administrator or Citigroup Inc.

Psychiatrist: A physician who specializes in mental, emotional, or behavioral disorders.

Psychologist: A person who specializes in clinical psychology and fulfills one of these requirements:

- A person licensed or certified as a psychologist or
- A Member or Fellow of the American Psychological Association, if there is no government licensure or certification required.

Rehabilitation facility: A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Room and board: Room, board, general-duty nursing, intensive nursing care by whatever name called, and any other services regularly furnished by the hospital as a condition of occupancy of the class of accommodations occupied, but not including professional services of physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

Self-insured or self-funded plan: A plan in which no insurance company or service plan collects premiums and assumes risk.

Sickness: Bodily disorder or disease. The term "sickness" used in connection with newborn children will include congenital defects and birth abnormalities, including premature births.

Skilled nursing facility: A facility, if approved by Medicare as a skilled nursing facility, is covered by this Plan. If not approved by Medicare, the facility may be covered if it meets the following tests:

- It is operated under the applicable licensing and other laws;
- It is under the supervision of a licensed physician or registered nurse (RN) who is devoting full time to supervision;
- It is regularly engaged in providing room and board and continuously provides 24/7 skilled nursing care of sick and injured persons at the patient's expense during the convalescent stage of an injury or sickness;
- It maintains a daily medical record of each patient who is under the care of a licensed physician;
- It is authorized to administer medication to patients on the order of a licensed physician; and
- It is not, other than incidentally, a home for the aged, the blind or the deaf, a hotel, a domiciliary care home, a maternity home, or a home for alcoholics or drug addicts or the mentally ill.

A skilled nursing facility that is part of a hospital will be considered a skilled nursing facility for the purposes of the Plan.

Treatment center: A facility that provides a program of effective mental health and chemical dependency treatment and meets all of the following requirements:

- It is established and operated in accordance with any applicable state law;
- It provides a program of treatment approved by a physician and the Claims Administrator;
- It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the patient;

- It provides at least the following basic services:
  - Room and board (to the extent that this Plan provides inpatient benefits at a Treatment Center);
  - Evaluation and diagnosis;
  - Counseling by a licensed provider; and
  - Referral and orientation to specialized community resources.

Treatment centers that qualify as a hospital are covered as a hospital and not as a treatment center.

Urgent care: Conditions or services that are non-preventive or non-routine and are needed to prevent the serious deterioration of a member's health following an unforeseen illness, injury, or condition. Urgent care includes conditions that could not be adequately managed without immediate care or treatment, but do not require the level of care provided in the emergency room.

Urgent care facility/center

- **Aetna:** Urgent care is the delivery of ambulatory care in a facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Often urgent care centers are not open on a continuous basis, unlike a hospital emergency room which would be open at all times.
- **Empire BlueCross BlueShield:** A facility dedicated to the delivery of medical care outside of a hospital emergency department, usually on an unscheduled, walk-in basis. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room.
- **Oxford:** A medical care facility that provides care for a condition that needs immediate attention to minimize the severity and prevent complications but is not a medical emergency. Urgent care facilities are covered in or out of the service area. Precertification is not required for Plan urgent care treatment when provided by facilities that are specifically contracted by Oxford as urgent care providers. Members should contact the number on the back of their ID cards for instructions.

Utilization review: A review and determination as to the medical necessity of services and supplies.

Glossary

For More Information

Telephone

ConnectOne: 1-800-881-3938

- From outside the United States and Puerto Rico: Call the Citi Employee Services (CES) North America Service Center at 1-469-220-9600. Press 1 when prompted.
- If you use a TDD: Call the Telecommunications Relay Service at 711. Then call ConnectOne at 1-800-881-3938.

Web

If you have intranet or Internet access, you can review many of your benefits and obtain benefits information and enroll through the Total Comp @ Citi website at **www.totalcomponline.com**, available from the Citi intranet and the Internet. From the "Quick Links" page, you can link to some of the Citi benefits providers without an additional login.

For information about these topics, plans, or programs	Contact	Telephone number/Web address
Beneficiary designations • Basic Life/AD&D, Citigroup 401(k) Plan, Citibuilder 401(k) Plan for Puerto Rico, and Citigroup Pension Plan	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
• Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (GUL)	1-800-523-2894 Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "MetLife MyBenefits Web Site
Benefits (health and welfare)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit Your Benefits Resources through Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
Citi Live Well Program	Health Advocate and ActiveHealth	1-866-449-9933 Visit the **Citi Live Well Portal** through Total Comp @ Citi at **www.totalcomponline.com** or **www.activehealthportal.net/citi**.
COBRA coverage (Consolidated Omnibus Budget Reconciliation Act)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
Dental	CIGNA Dental HMO MetLife Preferred Dentist Program (PDP)	1-800-244-6224 **www.mycigna.com** (participants only) 1-888-832-2576 **www.metlife.com/dental**
Dependent Day Care Spending Account	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."

For More Information

For information about these topics, plans, or programs	Contact	Telephone number/Web address
Disability To report a disability and for information about the Short-Term Disability (STD) and Long-Term Disability (LTD) benefit and the Family and Medical Leave Act (FMLA) You can also report a disability to MetLife directly by phone or online.	MetLife	Call ConnectOne. From the ConnectOne main menu choose the "Managed Disability" option. 1-888-830-7380 Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "MetLife MyBenefits Web Site
Employee Assistance Program (EAP)	Harris Rothenberg	1-800-952-1245 1-800-256-1604 (TDD) Outside the United States, call collect to 212-422-8847. **www.harrisrothenberg.com** User ID: resources Password: for_you
General information Eligibility, enrollment, general information about the health and welfare benefits plans, status changes, and continuing coverage after a termination of employment	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
Group Universal Life (GUL)/Supplemental AD&D insurance	MetLife (GUL)	1-800-523-2894 Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "MetLife MyBenefits Web Site
Health Savings Account	ConnectYourCare	1-888-846-6414 **www.connectyourcare.com**
HIPAA Certificate of Creditable Coverage	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option.
HMOs	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option.
Insurance • Basic Life/Accidental Death and Dismemberment (AD&D) insurance • Business Travel Accident/Medical insurance	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu, choose the "health and welfare benefits" option.
Limited Purpose Health Care Spending Account	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
Long-Term Care insurance	John Hancock Life Insurance Co.	1-800-222-6814 **http://groupltc.jhancock.com** User name: groupltc Password: mybenefit
Medical (non-HMOs plans)	Aetna (ChoicePlan 500, High Deductible Health Plan-Basic and Premier) Empire BlueCross BlueShield (ChoicePlan 500) Oxford Health Plans PPO (CT, NJ, NY tri-state area only) UnitedHealthcare (Hawaii Health Plan)	1-800-545-5862 1-800-628-3323 (TDD) **www.aetna.com** 1-866-290-9098 **www.empireblue.com/citi** 1-800-760-4566 or 1-800-444-6222 **www.oxhp.com** 1-877-311-7845 1-800-842-0090 (TDD) **www.provider.uhc.com/citigroup** (public site for Citi employees) **www.myuhc.com/groups/citi** (participants only)

For information about these topics, plans, or programs	Contact	Telephone number/Web address
Plan documents For the health and welfare plans	Benefits Handbook website	**www.benefitsbookonline.com** If you do not have access to the Citi intranet or the Internet, you can request a copy of the Plan documents at no cost to you by speaking with a Citi Benefits Center representative through ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option.
Prescription Drug Program (ChoicePlan 500, High Deductible Health Plan- Basic and Premier, and Hawaii Health Plan) To refill an Express Scripts Home Delivery prescription using the automated system; for instructions on how your doctor can fax your prescription to the Express Scripts Pharmacy; to arrange credit card payment for all your Home Delivery pharmacy service orders Prior authorization	Express Scripts	1-800-227-8338 1-800-899-2114 (TDD) https://member.express-scripts.com/preview/citigroup2009 (public site for Citi employees) **www.express-scripts.com** (participants only) 1-800-224-5498
Transportation Reimbursement Incentive Program (TRIP)	Citi Benefits Center	Call ConnectOne. From the ConnectOne main menu choose the "health and welfare benefits" option. Visit Total Comp @ Citi at **www.totalcomponline.com**. From the "Quick Links" page, click on "Your Benefits Resources™."
Vision For Plan information and laser vision correction providers/arrangements	Davis Vision	1-877-923-2847 Enter code 2227 **www.davisvision.com**
Workers' Compensation	Constitution State Services Co.	1-800-243-2490

CITI ON-SITE MEDICAL CLINICS	
Jacksonville, FL	
14000 Citicards Way	904-954-8262
Medical emergency number	904-954-8911
Tampa, FL	
Citibank Center, Building C	813-604-4333
Medical emergency number	611
Warren, NJ	
283 King George Road, Building C	908-563-5401
Medical emergency number	908-563-5412
New York metropolitan area	
399 Park Ave., Level A/Zone 11, New York City	212-559-3981
Medical emergency number	212-559-4357 (5-HELP)
111 Wall St., 23rd Floor, Zone 12, New York City	212-657-7478
Medical emergency number	212-657-4357 (6-HELP)
388 Greenwich St., 5th Floor, New York City	212-816-1460
Medical emergency number	212-816-1300
One Court Square, 9th Floor, Zone 7, Long Island City	718-248-2709
Medical emergency number	718-248-4357 (4-HELP)
San Antonio, TX	
100 Citibank Drive, Building 3	210-357-8275

For More Information

CITI HEALTH AND FITNESS CENTERS	
Florida	
14000 Citicards Way, Bldg. A, Jacksonville	904-954-2630
3800 Citibank Center Tampa	813-604-4348
Albuquerque, NM	
9521 San Mateo N.E.	505-797-6198
Warren, NJ	
283 King George Road	908-563-9534
New York City	
388 Greenwich St., 5th Floor, New York City	212-816-0523
One Court Square, 5th Floor, Long Island City	718-248-9571
Getzville, NY	
580 CrossPoint Parkway	716-730-7926
Texas	
100 Citibank Drive, San Antonio	210-677-6991
6400 Las Colinas Blvd, Irving	972-653-8890
3950 Regent Blvd, Irving	469-220-4177
Blue Ash, OH	
9997 Carver Rd	574-993-1032
Meridian, ID	
2200 South Cobalt Way	208-822-2331
Elk Grove Village, IL	
50 Northwest Point Blvd	224-222-2509
Kentucky	
4600 Houston Rd, Florence	859-283-3882
12501 Lakefront Place, Louisville	502-522-2401
McLeansville, NC	
5450 Millstream Road	336-522-1702
Hagerstown, MD	
14700 Citicorp Drive	301-714-5738
Kansas City, MO	
7920 NW 110th Street	816-420-1275
Las Vegas, NV	
8725 W. Sahara Blvd.	702-797-4855
Sioux Falls, SD	
701 East 60th Street N.	605-331-1922