Dental Plans

November 2001

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The dental plans

This section of the SPD describes the Citigroup dental benefits as of January 1, 2001. Citigroup has entered into an arrangement with MetLife and CIGNA Dental to administer the plans.

Citigroup offers two dental options to provide dental care for you and your eligible dependents. The two dental options are:

- MetLife 75 with preferred dentist program (MetLife 75); and
- CIGNA Dental Care DHMO.

This section of the SPD should be read in combination with the **About Your Health Care Benefits** section for more information about plan eligibility and enrollment for you and your dependents, coordination of benefits, your legal rights, your contributions, and other administrative details.

This section of the SPD is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual.

MetLife 75

MetLife 75 preferred dentist program (MetLife 75) is a preferred provider organization (PPO) consisting of a nationwide network of general and specialty dentists.

To locate a participating dentist:

- Visit the MetLife website at **www.metlife.com/dental**; or
- Call 1-800-474-7371.

When calling to make an appointment, let the dentist know that you participate in MetLife 75.

The following is a summary of features covered under MetLife 75. Types of services and limitations are outlined in the **Covered services and limitations** section.

Type of service	*Coverage**
Annual deductible	$75 per person; $225 per family
Annual maximum	$2,000 per person
Preventive and diagnostic services	100% of covered expenses with no deductible
Basic services	80% of covered expenses after deductible
Major services	50% of covered expenses after deductible
Orthodontia	50% of covered expenses after deductible
Lifetime orthodontia benefit (for children and adults)	$2,000 per person

*Network percentages are based on negotiated fees with participating providers. Out-of-network percentages are based on reasonable and customary charges. For more details, see the **Covered charges** section.

Covered services and limitations

Dental services are categorized into four services – preventive and diagnostic, basic, major, and orthodontia services. Below are descriptions of covered services and limitations by category.

Preventive and diagnostic

The following is a list of covered preventive and diagnostic services and limitations:

- Oral exams, maximum of two per calendar year;
- Routine cleanings, maximum of two per calendar year;
- Fluoride treatments (age 18 and under), maximum of one per calendar year;
- Space maintainers (age 18 and under);
- Full mouth and panoramic x-rays, once every 36 months;
- Bitewing x-rays, up to two full sets per calendar year;
- Sealants – permanent molars only (age 16 and under), one application every 36 months; and
- Palliative treatments.

Basic services

The following is a list of covered basic services and limitations:

- Fillings (except gold fillings), includes silver (amalgam), silicate, plastic, porcelain and composite fillings to restore injured or decayed teeth. Composite fillings for molars are not covered;
- Extractions;
- Endodontic treatment;
- Oral surgery, unless covered under your medical plan or your HMO;
- Repair prosthetics, no limit;
- Recementing (crowns, inlays, onlays, bridgework or dentures);
- Denture relining, once in 36 months;
- Periodontal treatment, includes gingival curettage;
- Bruxism appliance; and
- General anesthesia, when medically necessary, as determined by the Plan Administrator and administered in connection with a covered service.

Major services

The following is a list of covered major services and limitations:

- Inlays, onlays and crowns (including precision attachments for dentures), limited to one every five years;
- Removable dentures, initial installation, excludes adjustments made within the first six months;
- Removable dentures (replacement of an existing removable denture or fixed bridgework), limited to once every five years;
- Fixed bridgework, including inlays, onlays and crowns used to secure a bridge (initial installation);
- Fixed bridgework, including inlays, onlays and crowns used to secure a bridge (replacement of an existing removable denture or fixed bridgework with new fixed bridgework or adding teeth to existing fixed bridgework), limited to once every five years; and
- Dental implants (subject to consultant review).

Orthodontia services

The following is a list of covered orthodontia services:

- Orthodontic x-rays;
- Evaluation;
- Treatment plan and record;
- Removable and/or fixed appliance(s) insertion for interreceptive treatment;
- Temporomandibular joint (TMJ) disorder appliances (for TMJ dysfunction that does not result from an accident); and
- Harmful habit appliances, includes fixed or removable appliances.

Oral cancer services

Additional dental coverage may be available for those participants diagnosed with oral cancer.

How the Plan works

Dental 75 allows you to receive care from a MetLife preferred dentist and any other licensed dentist. At the time you need dental care, you decide whether to visit a preferred dentist or go to a dentist outside the preferred dentist program. The plan provisions (deductibles, coinsurance, and annual and lifetime maximums) will be the same whether your dentist is a participating provider or not. However, using preferred dentists can reduce your costs.

Annual deductible and maximum

Before benefits can be paid in a calendar year, you and/or your covered dependent(s) must meet the $75 individual or $225 family deductible. The deductible does not apply to preventive and diagnostic services. However, the deductible does apply to basic, major, and orthodontia services.

You can meet the family deductible as follows:

- Up to three people in a family: each member must meet the individual deductible; or
- Four or more people in a family: expenses can be combined to meet the family deductible. However, no one person can apply more than the $75 individual deductible toward the $225 family deductible.

You and/or your covered dependent(s) have an annual maximum benefit of $2,000 per person.

Covered charges

After you have met the deductible, Dental 75 reimburses covered charges for out-of-network dentists at a percentage of reasonable and customary (R&C) charges. For network charges, the percentage of reimbursement is based on negotiated fees with the network dentists.

A dental charge is incurred on the date the service is performed or the supply is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the “preparation date” is considered the date the charge is incurred. The claim will be paid in a lump sum (excluding orthodontia). For example, the completion date is considered for:

- Root canal therapy as the date the pulp chamber was opened;
- Crowns as the date the tooth was prepared for the crown;
- Partial and complete dentures as the date the impressions were taken; and
- Fixed bridgework as the date the abutment teeth were prepared for the bridge.

Orthodontic payments are paid differently. For example, if the orthodontic expense submitted is $3,000, the Plan will pay the 50% benefit, as follows:

Coverage for orthodontic appliance:

- $3,000 x 20% = $600 x 50% benefit = $300.
- First payment will be $300.

Coverage for monthly payments:

- $3,000 - $600 = $2,400.
- $2,400 ÷ 24 months = $100 x 50% benefit = $50.
- Monthly payment will be $50.

A monthly payment of $50 will be made over the course of treatment. The first payment will be based on 20% of the expense to cover the appliance fee. The remaining expense will be spread over the expected length of treatment, in this example, 24 months. Orthodontic benefits are subject to the calendar year deductible and the $2,000 lifetime orthodontic maximum.

Before you receive care

Before you receive certain dental services, you are advised to discuss the treatment plan with your dentist to determine what is covered.

Predetermination of benefits

Before starting a dental treatment for which the charge is expected to be $300 or more, you should request a predetermination of benefits using a MetLife dental claim form. Complete the employee section of the form, ask your dentist to itemize all recommended services and costs, and send the form to the Claims Administrator at the address on the form.

The Claims Administrator will notify you and your dentist of the benefits payable under the Plan. You and/or your dependent(s) and the dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed and an estimate of the dentist's fees are not submitted in advance, the Plan reserves the right to determine benefits payable by taking into account alternative procedures, services, or courses of treatment based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable, or may not be paid.

Alternative treatment

Many dental conditions can be treated in more than one way. Dental 75 has an "alternate treatment" clause that governs the amount of benefits that will be paid for covered treatments.

If you choose a more expensive treatment – recommended by your dentist – than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payable will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and you and/or your dependent(s) and the dentist decide to use a gold filling, Dental 75 will base its reimbursement on the reasonable and customary charge for an amalgam filling. You will pay the difference in cost between the reimbursed amount and the dentist's charge.

Services not covered

Benefits are not provided for services and supplies not medically necessary for the diagnosis or treatment of dental illness or injury. Dental services must be performed by a dentist licensed to practice in the state or by a legally qualified physician. A dentist is a doctor of dental surgery or a doctor of medical dentistry.

The Plan Administrator, acting through the Claims Administrator, reserves the right to determine whether, in its judgment, a service or supply is medically necessary or payable under this Plan. The fact that a dentist has prescribed, ordered, recommended, or approved a service or supply does not, in itself, make it medically necessary.

The following exclusions apply to Dental 75 and are **not** provided for:

- Dental care received from a dental department maintained by an employer, mutual benefit association, or similar group;
- Treatment performed for cosmetic purposes;
- Treatment by anyone other than a licensed dentist, except for dental prophylaxis performed by a licensed dental hygienist under the supervision of a licensed dentist;
- Services in connection with dentures, bridgework, crowns, and prosthetics if for:
  - Prosthetics started before the patient became covered;
  - Replacement within five years of a prior placement covered under this Plan;
  - Extensions of bridges or prosthetics paid for under this Plan, unless into new areas;
  - Replacement due to loss or theft;
  - Teeth that are restorable by other means or for the purpose of periodontal splinting; and
  - Connecting (splint) teeth, changing or altering the way the teeth meet, restoring the bite (occlusion), or making cosmetic changes.
- Any work done or appliance used to increase the distance between nose and chin (vertical dimension);
- Facings or veneers on molar crowns or molar false teeth;
- Training or supplies used to educate people on the care of teeth;
- Charges for crowns and fillings not covered under basic services;
- Any charges incurred for services or supplies not recommended by a licensed dentist;
- Any charges incurred due to sickness or injury that is covered by a Workers' Compensation Act or other similar legislation or arising out of or in the course of any employment or occupation whatsoever for wage or profit;
- Any charges incurred while confined in a hospital owned or operated by the U.S. government or an agency thereof for treatment of a service-connected disability;
- Any charges that, in the absence of this coverage, you would not be legally required to pay;
- Any charges incurred that result directly or indirectly from war (whether declared or undeclared);
- Any charges resulting from injury that is intentionally self-inflicted or from injury sustained while committing an assault or felony;
- Any charges for services and supplies furnished for you or your eligible dependent(s) prior to the effective date of coverage or subsequent to the termination date of coverage;
- Any charges for services or supplies that are not generally accepted in the U.S. as being necessary and appropriate for the treatment of dental conditions including experimental care;
- Any charges for nutritional supplements and vitamins;
- Services covered by motor vehicle liability insurance;
- Services that would be provided free of charge but for coverage;
- Broken appointments;
- Charges for filing claims or charges for copies of x-rays;
- Any charges for services rendered to sound and natural teeth injured in an accident;
- Care and treatment that is in excess of the reasonable and customary charge; and
- Services that, to any extent, are payable under any medical benefits, including HMOs.

CIGNA Dental Care DHMO

CIGNA Dental Care DHMO is a managed dental care plan. CIGNA Dental contracts with network dentists in most areas of the country. Network dentists provide covered services to CIGNA Dental members at independently owned network dental offices. You can request a list of network dental offices in your area by calling CIGNA Dental at 1-800-367-1037.

Enrollment in the CIGNA Dental Care DHMO allows the release of the enrolled member's dental records to CIGNA Dental for administrative purposes.

The CIGNA Dental Care DHMO has no annual individual or family deductibles and no lifetime dollar maximums. Most preventive services are 100% paid when you use a network dentist. You pay a patient charge when you use a network dentist for other services. You can obtain a schedule of charges by calling CIGNA Dental at 1-800-367-1037.

Type of service	*Coverage*
Annual deductible	None
Annual maximum	None
Preventive and diagnostic services	Most services covered at 100% (certain limitations apply)
Basic services	Based on the patient charge schedule
Major services	Based on the patient charge schedule
Orthodontia	Based on the patient charge schedule
Lifetime orthodontia benefit (for children and adults)	Based on the patient charge schedule Coverage limited to 24 months of treatment. Atypical cases or cases longer than 24 months require additional payment by the patient.

Limitations and services not covered

Listed below are limitations and services not covered by the CIGNA Dental Care DHMO:

- **Frequency**. The frequency of certain covered services, such as cleanings, is limited. The patient charge schedule lists any limitations on frequency;
- **Specialty care.** Payment authorization is required for coverage of services by a network specialist;
- **Pediatric dentistry.** Coverage for referral to a pediatric dentist ends on an enrolled child's 7th birthday; however, exceptions for medical reasons may be considered on an individual basis. The network general dentist shall provide care after the child's 7th birthday; and
- **Oral surgery.** The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.
- **Orthodontia.** CIGNA Dental does not cover orthodontia treatment in progress started with another carrier.

Listed below are the services or expenses that are **not** covered under the CIGNA Dental Care Plan DHMO. These services are your responsibility and are billed by the dentist at his/her usual fee:

- Services not listed on the patient charge schedule, as described later in this section;
- Services provided by an out-of-network dentist without CIGNA Dental's prior approval (except emergencies, as described later);
- Services related to an injury or illness covered under Workers' Compensation, occupational disease or similar laws;
- For **Florida** residents, this exclusion relates to such services paid under Workers' Compensation, occupational disease or similar laws;
- Services provided or paid by or through a federal or state governmental agency or authority, political subdivision or a public program other than Medicaid;
- Services relating to injuries which are intentionally self-inflicted (For **Texas** and **Ohio** residents, this exclusion does **not** apply);
- Services required while serving in the armed forces of any country or international authority or relating to a declared or undeclared war or acts of war;
- Cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance);
- General anesthesia, sedation and nitrous oxide (For **Maryland** residents, general anesthesia is covered when medically necessary and authorized by your physician);
- Prescription drugs;
- Procedures, appliances or restorations if the main purpose is to change vertical dimension (degree of separation of the jaw when teeth are in contact) or diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed on the patient charge schedule;
- The completion of crown and bridge, dentures or root canal treatment already in progress on the date you become covered by the Plan (For **Texas** residents, this exclusion does **not** apply);
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
- Services associated with the placement or prosthodontic restoration of a dental implant;
- Services considered unnecessary or experimental in nature (For **Pennsylvania** residents, this exclusion applies only to services considered experimental in nature. For **Maryland** residents, this exclusion applies only to services considered unnecessary);
- Procedures or appliances for minor tooth guidance or to control harmful habits;
- Hospitalization, including any associated incremental charges for dental services performed in a hospital;
- Services to the extent you are compensated for them under any group medical plan, no-fault auto insurance policy, or insured motorist policy (For **Arizona** residents, this exclusion does **not** apply. For **Kentucky** and **North Carolina** residents, this exclusion does **not** apply to services compensated under no-fault auto or insured motorist policies. For **Maryland** residents, this exclusion does **not** apply to services compensated under group medical plans. For **Pennsylvania** residents, this exclusion does **not** apply);

Except for the limitations listed above, preexisting conditions are not excluded. For **Texas** residents, preexisting conditions are not excluded.

How the Plan works

When you enroll in CIGNA Dental Care DHMO, you must select a network dental office. If your first or second choice is not available, the network dental office nearest your home will be selected for you.

You can choose a different dentist in the network for yourself and each of your dependents. When you visit a network office, you will pay the amount shown on your patient charge schedule for covered services. If you undergo a procedure that is not on your patient charge schedule, you will pay the dentist's usual charges. If you visit an office other than your network dental office, you will pay the dentist's usual charges, except for emergencies or as authorized by CIGNA Dental.

Specialized care

If your network general dentist determines that you need specialized dental care, your network general dentist will begin the specialty referral process. Follow your network general dentist's instructions regarding access to specialty care. Care from a network specialist is covered when CIGNA Dental authorizes payment. Treatment by a network specialist must begin within 90 days from the date of CIGNA Dental's authorization.

If you receive specialty care, and payment is not authorized by CIGNA Dental, you may be responsible for the network specialist's usual charges.

Changing your dentist

If you decide to change your network dental office, CIGNA Dental can arrange a transfer. You and your enrolled dependents may each transfer to a different network general dentist. You should complete any dental procedure in progress before transferring to another dental office.

To arrange a transfer, call Member Services at 1-800-367-1037. Your transfer request will take about five days to process. Transfers generally will be effective the first day of the month after the processing of your request. Unless you have an emergency, you will be unable to schedule an appointment at the new dental office until your transfer becomes effective.

There is no charge to you for the transfer. However, all patient charges that you owe to your current dental office should be paid before the transfer can be processed.

Appointments

To make an appointment with your network general dentist, call the dental office that you have selected. When you call, your dental office will ask for your identification number (Social Security number) and will check your eligibility.

Broken appointments

The time your network general dentist schedules for your appointment is valuable to you and the dentist. Broken appointments make it difficult for your dental office to maintain a schedule that is convenient for you and efficient for the staff. The delay in treatment resulting from a broken appointment can turn a minor problem into a complex one resulting in higher cost to you, your dentist, and CIGNA Dental.

If you or your enrolled dependent breaks an appointment with less than 24 hours' notice to the dental office, you may be charged a broken appointment fee for each 15 minute block of time that was reserved for your care. Consult your patient charge schedule for maximum charges for broken appointments (not applicable in **Texas**).

Patient charge schedule

The patient charge schedule lists the benefits of the CIGNA Dental Care DHMO including covered procedures and patient charges. Patients pay the patient charges listed when the procedures are performed by a network general dentist. Procedures performed by a non-network dentist are not covered and patients will be charged the dentist's usual fee for those procedures. Procedures not listed on the patient charge schedule are not covered and are the patient's responsibility at the dentist's usual fees. You may request a patient charge schedule by calling CIGNA Dental at 1-800-367-1037.

Emergencies

An emergency is a dental condition of recent onset and severity which would lead a prudent layperson possessing an average knowledge of dentistry to believe the condition needs immediate dental procedures necessary to control excessive bleeding, relieve severe pain, or eliminate acute infection. You should contact your Network general dentist if you have an emergency. In Pennsylvania and Texas, you will be reimbursed so that your out-of-pocket expenses will be the same as if you visited your network dentist.

Away from home

If you have an emergency while you are out of your service area or unable to contact your network general dentist, you may receive emergency covered services from any general dentist. Routine restorative procedures or definitive treatment (e.g., root canal) are not considered emergency care. You should return to your network general dentist for these procedures. For emergency covered services, you will be responsible for the patient charges listed on your patient charge schedule. CIGNA Dental will reimburse you the difference, if any, between the dentist's usual fee for emergency covered services and your patient charge, up to a total of $50 per incident.

To receive reimbursement, send appropriate reports and x-rays to the CIGNA Dental address listed below.

For residents of **Arizona**, **California**, **Colorado** and **New Mexico:**

CIGNA Dental
5990 Sepulveda Boulevard
Suite 500
Van Nuys, CA 91411

For residents of all other states:

CIGNA Dental
P.O. Box 189060
Plantation, FL 33318-9060

After hours

There is a patient charge listed on your patient charge schedule for emergency care rendered after regularly scheduled office hours. This charge will be in addition to other applicable patient charges.

Member Services

If you have any questions or concerns about CIGNA Dental, call Member Services at 1-800-367-1037. A representative can:

- Provide information on network dental offices in your area;
- Arrange a dental office transfer, a second opinion, or a consultation;
- Act as your liaison with your dental office; and
- Explain your benefits.

Converting coverage

If you and/or your enrolled dependents are no longer eligible for coverage, you and/or your enrolled dependents can convert to an individual dental plan unless benefits were discontinued due to:

- Permanent breakdown of the dentist-patient relationship;
- Fraud or misuse of dental services and/or dental offices;
- Nonpayment of premiums; or
- Selection of alternate dental coverage by your employer.

Benefits and rates for an individual dental plan will be at the prevailing conversion levels and may not be the same as those for Citigroup. Call the CIGNA Dental Health Conversion Department at 1-800-367-1037 to arrange to convert to an individual dental plan.

Extension of benefits

Coverage for a dental procedure, other than orthodontics, which was started before you dropped coverage, will be extended for 90 days after the date coverage ends unless coverage loss was due to nonpayment of premiums.

Coverage for orthodontic treatment, started before you dropped coverage, will be extended to the end of the quarter or for 60 days after the date coverage ends, whichever is later, unless coverage loss was due to nonpayment of premiums.

Appeals procedure

If you have a concern about your dental office or the CIGNA Dental Care DHMO, call 1-800-367-1037 and explain your concern to a Member Services representative. The representative will attempt to respond or get back to you as soon as possible, usually by the end of the next business day.

CIGNA Dental has a procedure for complaints and appeals. The complaint and appeal process is governed by state law. Time frames may vary accordingly.

Level one appeal

To initiate an appeal, you must submit a request in writing to the CIGNA Dental Plan within one year from the date of the initial CIGNA Dental decision or occurrence. You should state the reason why you believe your request should be approved and include any information supporting your request. If you are unable or choose not to write, you can ask Member Services to register your request when you call.

Your level one appeal will be considered and the resolution made by someone not involved in the initial decision or occurrence. Issues involving dental necessity or clinical appropriateness will be considered by a dental professional.

CIGNA Dental will respond with a decision within 30 calendar days after your request is received. If the review cannot be completed within 30 days, CIGNA Dental will notify you on or before the 30th day of the reason for the delay. The review will be completed within 15 calendar days after that.

- For **New Jersey** residents, CIGNA Dental will respond in writing within 15 working days;
- For **Colorado** residents, CIGNA Dental will respond within 20 working days; and
- For **Nebraska** residents, CIGNA Dental will respond within 15 working days if your complaint involves an adverse determination.

If you are not satisfied with the decision, you may request a second-level review. To initiate a level two appeal, you must submit your request in writing to CIGNA Dental within 60 days after receipt of CIGNA Dental's level one decision.

Level two appeal

Second-level reviews will be conducted by CIGNA Dental's Appeals Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the appeals committee. For appeals involving dental necessity or clinical appropriateness, the committee will include at least one dentist. If specialty care is in dispute, the committee will consult with a dentist in the same or similar specialty as the care under consideration, as determined by CIGNA Dental.

CIGNA Dental will acknowledge your appeal in writing within five business days and schedule a committee review. The acknowledgment will include the name, address, and telephone number of the appeals coordinator. Additional information may be requested at that time. The review will be held within 30 calendar days. If the review cannot be completed within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 days after receipt of your request.

You may present your situation to the committee in person or by conference call. Please advise CIGNA Dental five days in advance if you or your representative plans to be present. You will be notified in writing of the committee's decision within five business days after the committee meeting. The resolution will include the specific contractual or clinical reasons for the resolution, as applicable.

Expedited appeal

You may request that the complaint or appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition. A dental professional, in consultation with the treating dentist, will decide if an expedited review is necessary. When a review is expedited, the Plan will respond orally with a decision within 72 hours, followed up in writing within two business days of the decision.

- For **Maryland** residents, CIGNA Dental will respond within 24 hours; and
- For **Texas** residents, CIGNA Dental will respond within one business day.

Independent review

If your appeal concerns a dental necessity issue and the appeals committee denies coverage, you may request that your appeal be referred to an independent review organization. To request a referral to an independent review organization, the reason for the denial must be based on a dental necessity determination by CIGNA Dental. Administrative, eligibility, or benefit coverage limits are not eligible for additional review under this process.

There is no charge to initiate this independent review process; however, you must provide written authorization permitting CIGNA Dental to release the information to the independent reviewer selected.

The independent review organization is composed of persons who are not employed by CIGNA Dental or any of its affiliates. CIGNA Dental will abide by the decision of the independent review organization.

To request a referral to an independent review organization, you must notify the appeals coordinator within 60 days of your receipt of the appeals committee's level two appeal review denial. CIGNA Dental will then forward the file to the independent review organization within 30 days.

The independent review organization will render an opinion within 30 days. When requested and when a delay would be detrimental to your dental condition, as determined by the Plan's dental director, the review shall be completed within three-to-five days.

The independent review program is a voluntary program arranged by the Plan and is not available in all areas.

Appeals to the state

You have the right to contact your state's Department of Insurance or Department of Health for assistance at any time.

CIGNA Dental will not cancel or refuse to renew coverage because you or your dependent has filed a complaint or appealed a decision made by CIGNA Dental. You have the right to file suit in a court of law for any claim involving the professional treatment performed by a dentist.

Disclosure Statement

CIGNA Dental refers to the following operating subsidiaries of CIGNA Corporation: Connecticut General Life Insurance Company and CIGNA Dental Health, Inc., and its operating subsidiaries. The CIGNA Dental Care Plan is provided by CIGNA Dental Health Plan of Arizona, Inc., CIGNA Dental Health of California, Inc., CIGNA Dental Health of Colorado, Inc., CIGNA Dental Health of Delaware, Inc., CIGNA Dental Health of Florida, Inc., a prepaid limited health services organization licensed under Chapter 636, Florida Statutes, CIGNA Dental Health of Kansas, Inc. (Kansas and Nebraska), CIGNA Dental Health of Kentucky, Inc., CIGNA Dental Health of Maryland, Inc., CIGNA Dental Health of New Jersey, Inc., CIGNA Dental Health of New Mexico, Inc., CIGNA Dental Health of North Carolina, Inc., CIGNA Dental Health of Ohio, Inc., CIGNA Dental Health of Pennsylvania, Inc., CIGNA Dental Health of Texas, Inc., CIGNA Dental Health of Virginia, Inc. In other states, the CIGNA Dental Care plan is underwritten by Connecticut General Life Insurance Company and administered by CIGNA Dental Health, Inc.

About Your Health Care Benefits

November 2001

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About your health care benefits

This document serves as both the Summary Plan Descriptions and official plan documents (hereinafter referred to as the “SPD”) for eligible employees under the health care benefit plans for Citigroup and Citibank and their operating companies. **Citigroup reserves the right to change or discontinue any or all of the benefits coverage or programs described here at any time, with or without notice.**

This SPD describes the benefits and programs available to Citigroup employees (hereinafter referred to as Citigroup, unless otherwise specified). The health care benefits summarized in this section describe the medical, dental and vision care plans, plus the health care and dependent care spending accounts, sponsored by Citigroup.

This SPD is intended to comply with the requirements of ERISA and other applicable laws and regulations. It does not create a contract or guarantee of employment between Citigroup and any individual. Your employment is always on an at-will basis. In addition, benefits under this SPD are not in any way subject to your or your dependent’s debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, or encumbered.

This SPD is designed to be your primary source of benefits information. Refer to it for information about your benefits, and share it with your family members.

This SPD provides no guarantee that you are eligible to participate in every benefit or program described. Each plan may have its own eligibility requirements, so be sure to review individual eligibility requirements carefully. In addition, Citigroup in no way guarantees the payment of any benefit which may be or become due to any person under the plan.

If you have any questions about this SPD or certain provisions of your benefit plans, please call your Benefit Service Center:

- **For Citigroup employees:** Call ConnectOne at 1-800-881-3938.
- **For Citibank employees:** Call the Employee Information & Services Line (EISL) at 1-800-947-2484.

Eligibility

Citigroup provides benefits coverage for you, your spouse or qualified domestic partner, and/or eligible dependents.

For employees

If you are a Citigroup employee:

You are considered a Citigroup employee if you work for American Health and Life Company, CitiFinancial, Citigroup Corporate Staff, Citigroup Investment Group, Primerica Financial Services, or National Benefit Life Insurance Company.

- You are eligible to enroll in Citigroup benefits on your date of employment if you are a full-time employee (regularly scheduled to work 40 hours or more a week) of one of the participating employers of Citigroup and you receive a regular semimonthly paycheck;
- You are also eligible to enroll in Citigroup benefits on your date of employment if you are a part-time employee (regularly scheduled to work 20 or more hours a week) of any participating employers of Citigroup Inc. except Primerica Financial Services and National Benefit Life;
- If eligible, you also can enroll your eligible dependents for coverage as of your date of employment;
- If you are eligible to enroll in Citigroup benefits, you also can enroll your eligible dependents in the medical, dental, vision care and group life insurance plans.

If you are a Citibank employee:

You are considered a Citibank employee if you work for Citibank NA and Participating Companies, CitiStreet Institutional Division, or CitiStreet Total Benefit Outsourcing.

- You are eligible to enroll in Citigroup benefits on your date of employment if you are classified as a regular employee of Citibank, N.A. or a participating company or are a member of the Citigroup Corporate Staff on the Citibank payroll. In all cases, you must have been hired to work 20 or more hours a week;
- If eligible, you also can enroll your eligible dependents for coverage as of your date of employment;
- If you are eligible to enroll in Citigroup benefits, you also can enroll your eligible dependents in the medical, dental, vision care and group life insurance plans.

If you both work for Citigroup:

If both you and your spouse or qualified domestic partner are employed by Citigroup or a participating company, neither of you can be covered both as an employee and a dependent for *any* Citigroup benefit plan.

- **Medical and dental** — Each of you may be covered under the medical and dental plans as either an employee or a dependent but not both. Either of you may cover your children, but they cannot be covered by both of you.
- **Health care spending account** — Either of you may be covered under a health care spending account but you may not file more than once for reimbursement of the same eligible expense. Your qualified domestic partner and eligible child(ren) are eligible, provided they are considered tax dependents under Section 152 of the Internal Revenue Code (IRC).

- **Dependent care spending account** — If you file a joint federal income tax return, you and your spouse together may not contribute more than $5,000 on a pre-tax basis to this account. If you are married and you and your spouse file separate federal income tax returns, the maximum you may contribute is $2,500. Due to federal tax law, qualified domestic partners are not eligible to participate in a dependent care spending account.

For dependents

Your eligible dependents are:

- Your lawfully married spouse or state-recognized common-law spouse;
- Each of your children who is unmarried, relies on you for financial support, and is:
- Under the age of 19 years*; or
- Under the age of 25* and a full-time student (meaning the student is enrolled in courses totaling 12 or more credits per semester) who is attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claims Administrator. The names, addresses and phone numbers of the health care Claims Administrators are listed in the **Plan names and numbers** sections of this SPD.

A child primarily relies on you for a majority of his or her financial support if:

- You are providing more than 50% of the child's support; and
- You claim the child as a dependent on your annual tax return filed with the Internal Revenue Service (Form 1040).

*Coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full time student. Coverage will remain in effect through the end of the month in which the child gets married or obtains a full time job.

Eligible dependent children are further defined as:

- Your natural children;
- Your legally adopted children (For purposes of coverage under the medical and dental plans, adopted children will be considered eligible dependents when they are placed in your home in anticipation of adoption, when primary financial support begins, or when the adoption becomes final, whichever occurs first.);
- Your stepchildren who live in your household full-time in a regular parent-child relationship;
- A child permanently residing in your household for whom you are the legal guardian. You must provide proof of guardianship in writing to the Claims Administrator;
- Eligible dependents also include an employee's domestic partner and/or his or her children, provided the children of the domestic partner meet all the other qualifications of dependent children, as described in this section.

As required by the Federal Omnibus Budget Reconciliation Act of 1993, any child of a plan participant who is an alternate recipient under a Qualified Medical Child Support Order (QMCSO) will be considered as having a right to dependent coverage under the medical and dental plans. In general, QMCSOs are state court orders requiring a parent to provide medical support to an eligible child, for example, in the case of a divorce or separation. For a detailed description of the procedures for a QMCSO, contact the Plans Administration Committee.

If one of your eligible dependent children becomes incapable of self-sustaining employment due to a mental or physical disability and is covered under the medical or dental plan before reaching age 19, or age 25 if a full-time student, this child may continue to be considered an eligible dependent under the medical or dental plan beyond the date his/her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end and as requested thereafter. This eligible dependent must still meet all other eligibility qualifications for coverage to be continued.

No person will be covered under this plan both as an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Dependent notification

The first time you enroll in Citigroup benefits, you will be asked to report information about each of your eligible dependents such as name, date of birth, Social Security number and, if over age 19, whether the child is a full-time student or has a mental or physical disability. *Without this information on file, you cannot enroll in any dependent coverage.*

If your dependent does not have a Social Security number at this time, you can enter dependent information and report the Social Security number after you obtain it.

You also must keep your dependent information current:

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

Dependents no longer eligible

Your spouse or qualified domestic partner is eligible for coverage until the last day of the month in which you become legally separated or divorced or submit a Domestic Partnership Termination Form.

Your dependent children are eligible for coverage until the earlier of the following dates:

The last day of the month in which they:

- Become employed full time;
- Get married; or
- Become eligible for coverage under any plan as employees.

or

- December 31 of the year in which they:
  - Reach age 19, if not full-time students (enrolled for 12 or more hours per semester) at an accredited school or college and primarily dependent on you for support, unless incapable of self-sustaining employment due to mental or physical disability;
  - Are over age 19 and stop attending school full time;
  - Reach age 25 if full-time students; or
  - Become able to support themselves after having been incapable of self-sustaining employment due to a mental or physical disability.

Newborns/newly adopted children

Even if you are not enrolled for dependent coverage, Citigroup will pay medical benefits for your newborn child from birth through 31 days.

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

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

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information about a new dependent even if you already have family coverage, or else your new dependent won't be covered.

For domestic partners

Where available, Citigroup allows you to cover your domestic partner and/or his or her children in the following plans:

- Medical (domestic partner benefits are not available through some HMOs);
- Dental;
- Health care spending account, provided your domestic partner and eligible dependent child(ren) are considered tax dependents under Section 152 of the IRC;
- Group universal life (GUL) insurance for domestic partners and term life insurance for children;
- Vision care plan; and
- Business travel accident insurance.

You cannot cover both a spouse and a domestic partner. To enroll a domestic partner and/or his or her children, an employee must sign an affidavit affirming that he or she meets Citigroup's eligibility criteria for domestic partner coverage, and complete a Certification of Domestic Partner's Tax Status. This form is available on CitiWeb or by calling your Benefit Service Center.

Your domestic partner can be of the same or opposite sex. To qualify for coverage as a domestic partner, you and your domestic partner must meet all of the following criteria:

- Currently reside together and intend to do so permanently;
- Have lived together for at least six consecutive months prior to enrollment and intend to do so permanently;
- Have mutually agreed to be responsible for each other's common welfare;
- Be at least 18 years of age and mentally competent to consent to contract;
- Are not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;

- Neither you nor your partner is legally married to another person;
- Neither you nor your partner is in a domestic partner relationship with anyone else; and
- Are in a relationship that is intended to be permanent and in which each of you is the sole domestic partner of the other.

To qualify for coverage, your domestic partner's unmarried child(ren) must be:

- The biological or adopted child of your domestic partner, a child for whom your domestic partner has legal guardianship, or a child who has been placed in your home for adoption; and
- Living with you and your domestic partner on a full-time basis, or living away at school; and
- Unmarried and under the age of 19*; or
- Unmarried and between the ages of 19 and 25* and attending school full-time; or
- Beyond age 19 and has a mental or physical disability.

*Coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. Coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job.

Termination of relationship

If you have enrolled your domestic partner and his or her children for medical, dental and/or vision care coverage and you terminate your domestic partnership, you must notify Citigroup by completing a Termination of Domestic Partnership Form within 31 days of the event. Contact your Benefit Service Center for this form. As a result, your domestic partner will be eligible to continue medical, dental, vision care and/or health care spending account coverage at his or her expense for a period of 36 months.

This coverage will be similar to COBRA coverage offered to spouses and other covered dependents, excluding domestic partners and their children. See the **COBRA** section for more information.

If you enroll a partner and terminate the domestic partner relationship, you must wait six months before enrolling a new domestic partner in a medical, dental or vision care plan sponsored by Citigroup.

Enrollment

You can enroll in Citigroup coverage within 31 days of the time you first become eligible or during the annual open enrollment period. The coverage available to you will be listed on your enrollment materials along with the enrollment deadline and how to enroll. You can enroll in any or all of the plans offered to you. For the medical and dental plans, you must choose a "coverage category." The four coverage categories are:

- Employee only;
- Employee + child(ren);
- Employee + spouse or domestic partner; and
- Employee + family.

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

Each category has a different cost. In addition, your cost for medical coverage will depend on your **total compensation** band as defined in this SPD. You will find your costs in your enrollment materials.

If you elect vision care coverage, you must also designate a level of coverage (one person, two people, or three or more people).

Other coverage

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

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

When coverage begins

If:	*Then:*
You enroll for yourself and your eligible dependents when first eligible.	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your date of hire or date of eligibility.
You do not enroll when first eligible.	Core benefits begin on your date of hire or date of eligibility, if later. (For more information about core benefits, see **If you do not enroll**.) All other benefits will begin on January 1 of the following year, provided you enroll during the annual enrollment period.
You enroll for yourself and your eligible dependents during the annual open enrollment period.	Coverage will begin on January 1 of the following year.
You enroll in medical, dental, vision care, and/or spending account coverage for yourself or a new dependent within 31 days of a family status change.	Coverage for yourself or your dependent(s) will begin on the date of the family status event, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

If you do not enroll

If you do not enroll in Citigroup benefits when first eligible, Citigroup will provide *only* the following coverage — known as core benefits — at no cost to you.

- Basic life insurance equal to your total compensation, up to $500,000, on your date of eligibility;
- Short-term disability (STD) coverage:
  For Citigroup employees: Replaces your annual base salary for an approved disability leave of up to 26 weeks. The percentage of salary replacement (100% or 66 -2/3%) will depend on your length of service. Your annual base salary at the start of your disability leave will be used to calculate your benefit. You are not eligible for salary increase during an approved STD leave.
  For Citibank employees: Replaces 66-2/3% of your annual base salary for an approved disability leave of up to six months. There are no service requirements for this benefit. Your annual base salary at the start of your disability leave will be used to calculate your benefit. You aren't eligible for salary increases during an approved STD leave.
- Basic long-term disability (LTD) coverage to replace 50% of total compensation, up to $100,000 in total compensation starting on the 181st day of an approved disability. Total compensation is determined on your date of eligibility and then each May 1 after that. These coverage amounts will be in effect for the calendar year unless your total compensation decreases due to a change in status from full-time to part-time employment or because you begin to receive LTD benefits.

Changing your coverage

During the year, you may want to change your coverage or coverage category. Citigroup has specific rules about when you can change your coverage.

For medical, dental and vision care coverage and the Health Care and Dependent Care Spending Accounts — the coverage you pay for with before-tax dollars — you can make changes only during the open enrollment period or as a result of certain events, such as marriage, the birth or adoption of a child, divorce, or the death of a dependent. These events are called *family status events. You must make any family status-related changes to your coverage within 31 days of the event.* See **Family status event.**

Type of coverage:	*When you can change your coverage or coverage category:*
Medical and dental	The annual open enrollment period or within 31 days of a family status event. Note: You can change your medical or dental plan election only as a result of your relocation out of your medical or dental plan's service area.
Vision care	The annual open enrollment period or within 31 days of a family status event.
Health Care and Dependent Care Spending Accounts	The annual open enrollment period or within 31 days of a family status event.

Midyear election changes

The federal government recently clarified the rules that govern when you can change benefit coverage elections outside of open enrollment. These rules apply to coverage elections you make for your medical, dental, vision care and spending accounts coverages. In general, the benefit plans and coverage levels you choose at open enrollment remain in effect for the following calendar year. However, you may be able to change your elections between annual enrollment periods if you have a family status event or other applicable event, as further explained below.

Family status events

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

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, or annulment;
- **Domestic partnership status:** You enter into or terminate a domestic partnership;
- **Number of dependents:** Any event that changes your number of tax dependents, including birth, death, adoption, and placement for adoption;
- **Employment status:** Any event that changes your, your spouse's, or your other dependent's employment status that results in gaining or losing eligibility for coverage. Examples include:
  - Beginning or terminating employment;
  - A strike or lockout;
  - Starting or returning from an unpaid leave of absence;
  - Changing from part-time to full-time employment or vice versa; and
  - A change in work location.
- **Dependent status:** Any event that causes your tax dependent to become eligible or ineligible for coverage because of age, student status, or similar circumstances;
- **Residence:** A change in the place of residence for you, your spouse or another dependent if outside your medical or dental plan's network service area.

Consistency requirements

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

Effect on eligibility: Except for the Dependent Care Spending Account, the family status event must affect eligibility for coverage under the plan or under a plan sponsored by the employer of your spouse or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the family status event results in an increase or decrease in the number of your dependents who may benefit from coverage under the plan.

For the Dependent Care Spending Account, the family status event must affect the amount of dependent care expenses eligible for reimbursement. For example, your child reaches age 13, and dependent care expenses are no longer eligible for reimbursement.

Corresponding election change: The election change must correspond with the family status event. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may cancel medical coverage only for that dependent.

Coverage & cost events

In some instances, you can make changes to your benefits coverage for other reasons, such as midyear events affecting your cost or coverage, as described below.

Coverage events

Medical and dental coverage: If Citigroup adds or eliminates a plan option in the middle of the plan year, or if Citigroup-sponsored coverage is significantly limited or ends, you and your eligible dependents can elect different coverage in accordance with Internal Revenue Service (IRS) regulations.

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

Also, if an election change is permitted during a different open enrollment period applicable to a plan of another employer (or, if applicable, to another plan sponsored by Citigroup), you may make a corresponding midyear election change. This rule applies to the medical, dental and vision care plans, as well as the Dependent Care Spending Account.

Lastly, if another employer's plan allows your spouse or other dependent to change his or her elections in accordance with IRS regulations, you may make a corresponding midyear election change to your coverage.

Dependent Care Spending Account: If your dependent care provider reduces or increases the number of hours worked, you may make a corresponding change to your Dependent Care Spending Account election. For example, if your child starts school, causing a reduction in the number of hours he or she is in the care of a dependent care provider, you may decrease your Dependent Care Spending Account election.

Cost events

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

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

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

Dependent Care Spending Account: If you change your dependent care provider midyear, you may change your Dependent Care Spending Account contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates midyear, you may increase or decrease your contributions.

Other rules

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

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

Special note regarding domestic partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a qualified domestic partner. However, IRS rules generally do not permit you to make a midyear change "on a *pre-tax* basis" for such events unless they involve a *tax* dependent. Thus, if you make a midyear change due to an event involving your domestic partner, that change must generally be made "on a *post-tax* basis," unless your domestic partner can be claimed as your dependent for federal income tax purposes. (Exceptions may be made if your domestic partner makes an election change under his or her employer's plan in accordance with IRS regulations.) Please see IRS Publication 502 for a discussion of the definition of a tax dependent. The publication is available at www.irs.gov/forms_pubs..

Changing your coverage status

You must make changes to your health benefits *within 31 days* of a family status event by calling your Benefit Service Center. The change will be effective on the date of your status change.

Your contributions

Your contributions for medical, dental, vision care, the Health Care Spending Account, and the Dependent Care Spending Account are taken on a before-tax basis and are based on the plan chosen and coverage category. Your total compensation is also used to determine your contribution for medical coverage.

For purposes of calculating your medical cost and coverage amounts for the following year, total compensation is determined each year on May 1, or your date of eligibility, if later. See your personal enrollment worksheet for the amount of your total compensation.

Total compensation bands on which employee contributions for medical coverage are based:		
$0.00	–	$19,999.99
$20,000.00	–	$24,999.99
$25,000.00	–	$39,999.99
$40,000.00	–	$59,999.99
$60,000.00	–	$79,999.99
$80,000.00	–	$99,999.99
$100,000.00	–	$149,999.99
$150,000.00	–	$249,999.99
$250,000.00	–	$499,999.99
More than $500,000		

Your total compensation may be made up of one or more of the following:

- **Base pay:** Annual rate of pay. For hourly employees, base pay is defined as your hourly rate times scheduled weekly hours times 52 weeks;
- **Bonus:** A bonus, excluding any sign-on bonus;
- **Differentials:** Off-hour premiums and other premiums delivered as a percentage of base pay;
- **Incentives/commissions:** Nonbonus payments that are based on performance and productivity and are generally recognized as part of a bona fide incentive plan; excludes, for example, spot awards, recognition programs, relocation, gross-ups, imputed income, and benefits; and
- **Overtime:** Included for some plans but not for any benefit described here.

Your total compensation amount will apply for the entire calendar year unless it decreases due to a change in status from full-time to part-time employment or because you begin to receive LTD benefits.

Before-tax contributions

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

Social Security taxes

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

Domestic partners

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

If your domestic partner and his or her child(ren) qualify as your dependents under Section 152 of the IRC, your contributions for domestic partner medical and dental coverage will be taken before taxes are withheld. However, if your partner and his or her child(ren) do not qualify as dependents under Section 152, you will pay for their medical and/or dental coverage with after-tax dollars.

Tax implications

According to federal tax law, your taxes may be affected when you enroll your domestic partner in Citigroup coverage.

If your domestic partner does NOT qualify as a tax dependent: If your domestic partner and his or her child(ren) do not satisfy the definition of a dependent under Section 152 of the IRC, the cost of any medical and/or dental coverage for your domestic partner and/or his or her child(ren) is considered "imputed income" and will be shown on your pay statement and Form W-2. You will pay taxes on the amount of imputed income.

If your domestic partner qualifies as a tax dependent: If your domestic partner and his or her child(ren) qualify as dependents under Section 152 of the IRC, your contributions for their medical and/or dental coverage will be taken before taxes are withheld, and there are no tax implications for you.

Since requirements are complex, you should consult a tax professional for advice on your personal situation.

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

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

To review the qualifications of a Section 152 dependent, see IRS Publication 501 Exemptions, Standard Deduction, and Filing Information at **www.irs.gov/forms_pubs/pubs.html**.

Coordination of benefits

Coordination of benefits provisions apply to the medical and dental plans only and are described in this section.

All payments under the plans described in this SPD will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication and works to the advantage of all members of the group.

When you or your dependent(s) are eligible for benefits under another group plan, the eligible expenses under this plan will be determined. One of the plans involved will pay benefits first — the Primary Plan — and the other plan(s) will pay benefits next — the Secondary Plan(s).

Allowable Expense: Includes any necessary, reasonable, and customary expense that would be covered in full or in part under the Citigroup plan. When a plan provides benefits in the form of furnishing services or supplies rather than cash payments, the service or supply will not be considered an allowable expense or a benefit paid.

Plan: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured), medical care components of group long-term care contracts (such as skilled nursing care), medical benefits under group or individual automobile contracts, Workers' Compensation, and Medicare or other governmental benefits, as permitted by law.

Primary Plan: A benefit plan that has primary liability for a claim.

Secondary Plan: A benefit plan that adjusts its benefits by the amount payable under the Primary Plan.

This plan will be the Primary Plan on claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children, the birthdays of the parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage (For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is the primary plan for your children). If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

If the Citigroup plan is the Primary Plan, it will pay benefits first. Benefits will be calculated according to the terms of the plan and will not be reduced due to benefits payable under other plans.

If the Citigroup plan is the Secondary Plan, benefits under the Citigroup plan may be reduced. The Claims Administrator will determine the amount the Citigroup plan normally would pay. Then the amount payable under the Primary Plan for the same expenses will be subtracted from the amount the Citigroup plan would have normally paid. The Citigroup plan will pay you the difference. If the Citigroup plan is Secondary, you will never be paid more for the same expenses under both the Citigroup plan and the Primary Plan than the Citigroup plan would have paid alone.

When the Citigroup plan is Secondary and the patient is covered under an HMO, benefits under the Citigroup plan will be limited to the copayment, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO.

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

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent not having custody of the child.

In the event that a legal conflict exists between two plans as to which is Primary and which is Secondary, the plan that has covered the patient for the longer time will be considered Primary. When a plan does not have a coordination of benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered Primary.

Coordination with Medicare

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

- Eligible active employees age 65 and over and who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citigroup plan on the basis of current employment status of the employee and who are entitled to Medicare benefits;
- Social Security disabled participants who are covered by the Citigroup plan on the basis of your active employment status with Citigroup and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD).

If you are entitled to Medicare and want Medicare as your primary coverage, you must decline Citigroup medical coverage. From that point forward, Medicare will be your only coverage, and no benefits will be provided by the Citigroup plan.

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

Facility of payment

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

Right of recovery

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

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

Release of information

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

Recovery provisions

Recovery provisions apply to the medical and dental plans and are described in this section.

Refund of Overpayments

Whenever payments have been made by the plan with respect to covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the plan's provision, you or your dependent(s) must make a refund to the plan in the amount paid in excess of the amount payable under the plan and help the plan obtain the refund from another person or organization.

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

Reimbursement

This section applies when a covered person recovers damages, by settlement, verdict or otherwise, for an injury, sickness or other condition. If the covered person has made, or in the future may make, such a recovery, including a recovery from an insurance carrier, the plan 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 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, shall promptly reimburse the plan from any settlement, verdict or insurance proceeds received by the covered person (or by the legal representatives, estate or heirs of the covered person), for the reasonable value of the medical benefits paid for or provided by the plan to the covered person.

In order to secure the right 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; and
- Assigns to the plan any benefits the covered person may have under any automobile policy or other coverage, to the extent of the plan's claim for reimbursement.

The covered person shall sign and deliver, at the request of the plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.

The covered person shall cooperate with the plan and its agents, and shall 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 making a full recovery of the reasonable value of the benefits provided. The covered person shall not take any action that prejudices the plan's right of reimbursement.

The plan shall be responsible only for those legal fees and expenses to which it agrees in writing, and shall not otherwise bear the costs of legal representatives retained by the covered person.

Subrogation

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

The plan is subrogated to the rights of the covered person against any party liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the reasonable 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 in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

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

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

When coverage ends

Your coverage automatically will terminate on the earliest of the following dates:

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

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

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

Continuing coverage

If you are on an approved leave of absence, call your Benefit Service Center about your rights to continue medical, dental, vision care and/or spending account coverage.

If you are unable to work because of total disability, you and your eligible dependent(s) may continue to be covered for 26 weeks. After you have been disabled for 26 weeks, if you are still disabled and/or long-term disability coverage is pending, your coverage will remain in effect. If you are no longer disabled and you do not return to work, your employment will terminate and your coverage and your eligible dependent's coverage will terminate.

If you have been employed by Citigroup for less than two years, you may continue medical, dental, vision care and/or spending account coverage for six months.

If, however, you have been employed by Citigroup and have been performing your regular employment duties in the customary manner for two or more years, you and your eligible dependents may continue coverage under a Citigroup plan for the period of time equal to the lesser of:

- Your length of service with Citigroup or any of its participating employers; or
- Five years.

Additionally, if you have more than five years of service with Citigroup or any of its participating employers, you and your eligible dependent(s) may continue medical coverage until you are eligible for Medicare solely by reason of reaching a particular age.

Regardless of the established leave policies mentioned above, as of August 5, 1993, the Citigroup plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

Continuing coverage during FMLA

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take up to 12 weeks of leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition.

If you take an unpaid leave of absence that qualifies under FMLA, medical, dental, and vision coverage for you and your dependents and your participation in the Health Care Spending Account may continue as long as you continue to contribute your share of the cost of coverage during the leave.

Note that your monthly contributions during a leave are made on an after-tax basis.

If you lose any coverage during an FMLA leave because you did not make the required contributions, you may reenroll when you return from your leave. Your coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave, you will be entitled to purchase continuation coverage for your medical, dental, vision and health care spending account benefits. If your employment is terminated while you are on an FMLA leave, you may also be eligible to continue your insurance coverage under COBRA.

Continuing coverage during military leave

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage (including medical, dental, vision, and Health Care Spending Account) for up to 18 months as long as you give Citigroup advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from Citigroup, does not exceed five years (with certain exceptions).

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

If you take a military leave, but your coverage under the plan is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plans Administration Committee determines whether an exclusion or waiting period applies once you are reinstated to the plan.

If you are on military leave for less than 18 months and you do not return to work at the end of your leave, you may be entitled to purchase continuation coverage for the remaining months, up to a total of 18 months.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act (COBRA), requires that most employers sponsoring group health plans offer employees and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the plan would otherwise end (called “qualifying events”). The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of the law.

You do not have to show that you are insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to your eligibility for coverage. Citigroup reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the plan.

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

Who is covered

If you are covered by a Citigroup or Citibank-sponsored medical, dental, vision care, or Health Care Spending Account, you have a right to choose this continuation coverage if you lose your group health coverage because of a reduction in your hours of employment or the termination of your employment (for reasons other than gross misconduct on your part). If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the FMLA leave period.

If you are the spouse of an employee and are covered by a Citigroup or Citibank-sponsored medical, dental, vision care, or Health Care Spending Account on the day before the qualifying event, you are a qualified beneficiary and have the right to choose continuation coverage for yourself if you lose group health coverage under a Citigroup-sponsored group health plan for any of the following four reasons:

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

If you are a covered dependent child of an employee covered by a Citigroup or Citibank-sponsored medical, dental, vision care, or Health Care Spending Account on the day before the qualifying event, you also are a qualified beneficiary and have the right to continuation coverage if group health coverage under such plan is lost for any of the following five reasons:

- The death of the employee;
- The termination of the employee’s employment (for reasons other than the employee’s gross misconduct) or reduction in the employee’s hours of employment;
- The employee’s divorce or legal separation;
- The employee becomes entitled to Medicare; or
- The dependent ceases to be a “dependent child” under the Citigroup or Citibank-sponsored medical, dental, vision, or Health Care Spending Account.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption, or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citigroup of the birth or adoption.

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

Separate Elections: Each qualified beneficiary has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified beneficiary who is eligible for continuation of coverage is entitled to make a separate election among the types of coverage. Thus, a spouse or dependent child is entitled to elect continuation coverage even if the covered employee does not make that election. Similarly, a spouse or dependent child may elect different coverage than the employee elects.

Your duties

Under the law, the employee or a family member has the responsibility to inform Citigroup of a divorce, legal separation, or a child losing dependent status under the Citigroup or Citibank-sponsored medical, dental, vision, or Health Care Spending Account. This notice *must* be provided within 60 days from the date of the divorce, legal separation or a child losing dependent status (or, if later, the date coverage would normally be lost because of the event).

If the employee or a family member fails to provide this notice to Citigroup during this 60-day notice period, any family member who loses coverage will *not* be offered the option to elect continuation coverage. The notice must be in writing.

- **For Citigroup employees:** Send the notice to H.R. Connection, One Tower Square – 1PB, Hartford, CT 06183
- **For Citibank employees:** Send the notice to Citigroup Service Center, P.O. Box 785004, 2300 Discovery Drive, Orlando, FL 32878.

When Citigroup is notified that one of these events has happened, Citigroup in turn will notify you that you have the right to choose continuation coverage. If you or your family member fails to notify Citigroup and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation, or a child losing dependent status, then the employee and family members will be required to reimburse the employer-sponsored group health plans for any claims mistakenly paid.

Citigroup's duties

Qualified beneficiaries will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage: The employee's death, termination (for reasons other than gross misconduct), reduction in hours of employment, or Medicare entitlement.

Electing COBRA

To elect or inquire about COBRA coverage, contact your Benefit Service Center.

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

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

Duration of COBRA

The law requires that you be afforded the opportunity to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) may occur while the continuation coverage is in effect.

These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You should notify Citigroup if a second qualifying event occurs during your continuation coverage period.

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

Special Rules for Disability. The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform Citigroup within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must inform Citigroup of this redetermination within 30 days of the date it is made at which time the 11-month extension will end.

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

Medicare. If you lose coverage (medical, dental, vision care, or Health Care Spending Account) due to your termination of employment or reduction in hours, your covered family member’s COBRA coverage will not end before 36 months from the date you become covered by Medicare.

Early termination of COBRA

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

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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose preexisting condition limitations. If you become covered by another group health plan and that plan contains a preexisting condition limitation that affects you, your COBRA coverage cannot be terminated. However, if the other plan's preexisting condition rule does not apply to you by reason of HIPAA's restrictions on preexisting condition clauses, the plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of nonpayment of premium during an FMLA leave, you are still eligible for COBRA on the last day of the FMLA leave, if you decide not to return to active employment. Your continuation coverage will begin on the earliest of the following to occur:

- When you definitively inform Citigroup that you are not returning at the end of the leave; or
- The end of the leave, assuming you do not return to work.

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

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

Cost of coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you may be required to pay up to 150% of the premium beginning with the 19th month of continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, Citigroup will notify you of any changes in the cost.

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

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

All notices and other communications regarding COBRA and the Citigroup-sponsored group health plan should be directed to ADP COBRA Services, P.O. Box 27478, Salt Lake City, UT 84127-0478 or by calling 1-800-422-7608.

Your HIPAA rights (medical only)

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 preexisting conditions. HIPAA also requires plans to provide a Certificate of Creditable Coverage and provide for special enrollment rights as described below.

Creditable coverage

Under HIPAA, preexisting exclusion periods generally can be no more than 12 months (or 18 months for late enrollees).

When you and your dependents no longer have Citigroup medical coverage, you will receive a Certificate of Creditable Coverage from the medical plan in which you were enrolled. The certificate provides evidence of Citigroup medical coverage. Present the certificate if you obtain coverage elsewhere.

Your special enrollment rights

If you decline to enroll for Citigroup 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 Citigroup 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 will have to wait until the next open enrollment period – or have another qualifying family status change or special enrollment right – to enroll.

To meet IRS regulations and plan requirements, Citigroup 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.

Claims and appeals

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

To file claims for:	*For Citigroup employees*	*For Citibank employees*
Medical ▪ For all plans other than HMOs. ▪ HMO participants: Call your HMO for any claim-filing information.	▪ You will receive a claims kit each year. If you need additional forms, contact your HR representative or your Benefit Service Center.	▪ Use one of the following forms available on CitiWeb: ▪ 301 – Aetna U.S. Healthcare Medical Claim Form (for Managed Choice POS plan participants); ▪ 316 – CIGNA Point of Service Claim Form (for FlexCare POS plan participants); ▪ 317 – UnitedHealthcare Claim Form (for Select Plus POS, Health Plan 2000, Health Plan 200, and Out-of-Area Plan participants); ▪ Or you may call Forms & LifeTimes option of the Employee Information & Service Line at 1-800-947-2484; outside the U.S., call 212-657-1999.
MetLife 75 with Preferred Dentist Program (PDP)	▪ Same procedure as Medical. See above.	▪ Use Form 318 – MetLife Dental Claim form available on CitiWeb; ▪ Or you may call Forms & LifeTimes option of the Employee Information & Service Line at 1-800-947-2484; outside the U.S., call 212-657-1999.
CIGNA Dental Care DHMO	▪ There are no claim forms to file under this plan.	▪ There are no claim forms to file under this plan.
Health Care Spending Account and Dependent Care Spending Account	▪ Same procedure as Medical. See above.	▪ Use Form 319 Spending Account Reimbursement Request Form available on CitiWeb; ▪ Or you may call Forms & LifeTimes option of the Employee Information & Service Line at 1-800-947-2484; outside the U.S., call 212-657-1999.
Vision Care Plan	▪ Call Davis Vision at 1-800-999-5431 or visit www.davisvision.com .	▪ Call Davis Vision at 1-800-999-5431 or visit www.davisvision.com .

Under ERISA, a Claims Administrator has 90 days to evaluate a claim, determine whether benefits will be paid, and notify you in writing with the status of your claim. In some cases, an additional 90 days may be needed and you will be notified of this during the first 90-day period.

You may receive an Explanation of Benefits indicating whether your claim was covered and if so, at what level. If you have questions, call the Plans Administration Committee directly.

If your claim is denied

If your claim is denied, in whole or in part, you will receive a written explanation detailing:

- The specific reasons for the denial;
- The specific references in the plan documentation on which the denial is based;
- A description of additional material or information you must provide to complete your claim and the reasons why that information is necessary;
- The steps to be taken to submit your claim for review; and
- The procedure for further review of your claim.

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 of the date of the written notification informing you that your claim was denied. Once you have requested this review, you may submit additional information and comments on your claim to the plan as long as you do so within 30 days of the date you asked for a review. During the 30-day period, you may review any pertinent documents held by the plan, if you make an appointment in writing to do so.

During the review, you will be given an opportunity to request a hearing and present your case in person or by an authorized representative at a hearing scheduled by the Claims Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

The Claims Administrator will conduct a full and fair review of your claim and appeal and notify you of its final decision within 60 days (120 days if special circumstances apply, which you will be notified about in writing prior to the expiration of the original 60-day period).

ERISA information

As a participant in Citigroup benefit plans, you have rights under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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

You may obtain copies of all plan documents and other plan information upon written request to the Plans Administration Committee. The Plans Administration Committee may charge a reasonable fee for copying the documents.

You may receive a copy of the plans' annual financial reports upon written request to the Plans Administration Committee.

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

You can reduce or eliminate an exclusionary period of coverage for preexisting conditions under your group health plan (if one exists), if you have creditable coverage from another plan. You should be provided a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurance issuer:

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

Without evidence of creditable coverage, you may be subject to a preexisting 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 plan 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 pension benefit or for exercising your rights under ERISA.

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

Under ERISA, there are steps you can take 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 Plans Administration Committee 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 Plans Administration Committee'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. If you believe the plan 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.

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 found your suit to be frivolous.

Answers to your questions

If you have questions about the plan, contact the Plans Administration Committee. If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the Plans Administration Committee, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington DC 20210. The Pension and Welfare Benefits Administration's New York City branch is located at 1633 Broadway, Room 226, New York, NY 10019. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Pension and Welfare Benefits Administration.

Administrative information

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

Future of the plans

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

Citigroup reserves the right to amend, modify, suspend, or terminate any plan, in whole or in part, at any time without prior notice. Citigroup may make any such amendment, modification, suspension, or termination of the plans. Citigroup's decision to change or terminate any of the plans may be due to changes in the federal or state laws governing retirement benefits, the requirements of the Internal Revenue Code or ERISA, or for any other reason.

Plan administration

The Plan Administrator and Claims Administrators are responsible for the general administration of the plan, and will be the fiduciaries to the extent not otherwise specified in this document or in an insurance contract. The Plan Administrator and Claims Administrators have the discretionary authority to construe and interpret the provisions of the plans and make factual determinations regarding all aspects of the plans and their benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the plan, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

The Plan Administrator and Claims Administrators may designate other organizations or persons to carry out specific fiduciary responsibilities in administering the plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the plan, including the processing and payment of claims under the plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the plan to the extent an insurer or administrator is not empowered with such responsibility.

Citigroup will administer the plan on a reasonable and nondiscriminatory 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 be controlling in all matters relating to the plan.

This SPD is intended to provide you with accurate and easy-to-understand information about your Citigroup benefits and summaries of the information you need to use your benefits.

Plan information

	Citigroup	Citibank
Employer Identification Number	52-1568099	13-5266470
Participating Companies	American Health and Life Company, CitiFinancial, Citigroup Corporate Staff, Citigroup Investment Group, Primerica Financial Services, and National Benefit Life Insurance Company	Citibank NA and Participating Companies, CitiStreet Institutional Division, and CitiStreet Total Benefit Outsourcing
Plan Names and Numbers		
▪ Medical plans (self-funded POS, Health Plan 2000, Health Plan 200, Out-of-Area Plan, and HMOs) including prescription drugs	Citigroup Health Benefit Plan ▪ Plan number 508	Medical Plan of Citibank, N.A. and Participating Companies ▪ Plan number 505
▪ Dental plans	Citigroup Dental Benefit Plan ▪ Plan number 505	Dental Plan of Citibank, N.A. and Participating Companies ▪ Plan number 503
▪ Vision care plan	Citigroup Vision Benefit Plan	Vision Plan of Citibank, N.A. and Participating Companies
▪ Spending accounts	Citigroup Flexible Benefits Plan ▪ Plan number 512	Flexible Spending Account Plan of Citibank, N.A. and Participating Companies ▪ Plan number 515
Plan Sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830	
Plan Administrator	Citigroup Inc. Plans Administration Committee 1 Court Square, 15th Floor Long Island City, NY 11120	

Claims Administrators

Plan	Claims Administrator
▪ For POS plans	Aetna U.S. Healthcare Citibank Claims Division 3541 Winchester Road Allentown, PA 18106-0911 1-800-545-5862 CIGNA HealthCare P. O. Box 36125 Charlotte, NC 28236 1-800-794-4953 UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-800-842-2884
▪ For HMO plans	Aetna U.S. Healthcare P. O. Box 16408 Pittsburgh, PA 15242 1-800-821-3808 CIGNA HealthCare P. O. Box 36125 Charlotte, NC 28236 1-800-794-4953 UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-800-842-2884
▪ For Health Plan 2000, Health Plan 2000, and Out-of-Area Plan	UnitedHealthcare P. O. Box 740800 Atlanta, GA 30374-0800 1-800-842-2884
▪ For Prescription Drug Program	
— Retail Pharmacy	PAID Prescription, L.L.C. P. O. Box 2187 Lee's Summit, MO 64063-2187
— Mail-Order Pharmacy	Merck-Medco Rx Services P. O. Box 182050 Cincinnati, OH 43218-2050
▪ For Dental Plans	
— MetLife 75 with Preferred Dentist Program (PDP)	Metropolitan Life Insurance Company MetLife Dental Claims Unit P. O. Box 14093 Lexington, KY 40512-4093 1-888-832-2576
— CIGNA Dental Care DHMO	CIGNA Dental/Member Services 300 NW 82nd Avenue Suite 700 Plantation, FL 33324 1-800-367-1037

▪ For Vision Care Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
▪ For Spending Accounts	UnitedHealthcare P. O. Box 925 Albany, NY 12201-0925 For Citigroup employees: 1-800-842-1168 For Citibank employees: 1-877-211-6551
Agent for Service of Legal Process	Citigroup Inc. General Counsel 399 Park Avenue, 3rd Floor New York, NY 10043
Plan Year	January 1 – December 31
Funding	With the exception of the CIGNA DHMO and the many fully insured HMOs, all plans are self-funded under which benefits are paid from the general assets of Citigroup, providing benefits for medical expenses. CIGNA DHMO is a fully insured plan. The cost of the employee and dependent coverage is shared by Citigroup and the participant.
Type of Administration	The plans are administered by the Plans Administration Committee. However, final decision on the payment of claims rest with the Claims Administrators. Benefits are paid from the general assets provided by the Plan Sponsor and from a trust qualified under Section 501(c)(9) of the Internal Revenue Code on behalf of the plans in accordance with the terms of their contracts. The Claims Administrators do not guarantee the benefits under the plan.

Notice required by the Florida Insurance Department: Some of these plans are self-insured group health plans not regulated by the Florida Insurance Department. Payment of claims is completely dependent upon the financial solvency of the employer or other entity sponsoring the plans. No guaranty fund exists to cover claims a bankrupt or otherwise insolvent employer or Plan Sponsor cannot pay.