About Your Health Care Benefits

Amended and Restated as of January 1, 2006

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Introduction

This document is a component of the plan documents for the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and the Health Care Spending Account (hereinafter referred to as the "Plans") for eligible employees of Citigroup and its participating employers (hereinafter referred to as Citigroup, unless otherwise specified). These Plans are also referred to herein as the "health care plans." **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.**

The benefits and programs described in this document are in effect as of January 1, 2006. The terms and conditions of these Plans may also be further prescribed in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

This document is intended to comply with the requirements of the Employee Retirement Income Security Act of 1974, as amended ("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 provided under the plans described in this document 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.

As you read the document you will see some terms that are bold and underlined. This means that the term is a reference to another section of the document.

This document 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 document or certain provisions of your benefit plans, or would like to receive copies of an insurance policy or other document forming a part of any Plan described in this document, please call the Benefit Service Center at ConnectOne at 1-800-881-3938 and select the Health Benefits options.

Eligibility

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

For employees

You are only eligible to participate in the health care plans (as defined above) if you work for a "participating employer" in the United States for a regular semimonthly or monthly paycheck as either an active full-time employee regularly scheduled to work 40 hours or more a week or an active part-time employee regularly scheduled to work 20 hours or more a week.

A "participating employer" is Citigroup Inc. and any subsidiary in which at least an 80% interest is owned. The Corporate and Investment Bank, Global Wealth Management, the Global Consumer Group, Citigroup Alternative Investments and the Citigroup Corporate Center are the Citigroup businesses that participate in the Plans.

For purposes of determining whether you are an eligible employee under the health care plans, you are an "active" employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, scheduled days off or approved leaves of absence not due to disability.

You are not an eligible employee and can not participate in the Plans if:

- your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating employer;
- you are employed by a Citigroup subsidiary or affiliate that is not a participating employer;
- you are engaged under an agreement that states you are not eligible to participate in the Plans;
- you are a non-resident alien performing services outside the United States; or
- you are classified by Citigroup as an independent contractor or consultant, or as being employed on a temporary basis.

If you are a U.S. citizen or legal resident employed outside the United States in an expatriate classification, your eligibility will be determined in accordance with practices and procedures established under the Plans.

If you both work for Citigroup

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

- **Medical, dental, and vision care —** 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. However, your qualified domestic partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of section 152 of the Internal Revenue Code of 1986, as amended (the "Code"), as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

For dependents

Your eligible dependents are:

- Your lawfully married spouse or state-recognized common-law spouse; if you are legally separated, your spouse is not an eligible dependent unless mandated by state law.
- Each of your children who is unmarried and a "qualifying child" as defined in section 152(c) of the Code. Generally, a qualifying child must have the same principal place of residence as you for more than half the year, must not provide over one-half of his or her own financial support, and:
  - will attain age 18* as of the close of the plan year or is younger; or
  - will attain age 23* as of the close of the plan year or is younger, and is a full-time student (meaning the student is enrolled full-time in courses for at least 5 months during the plan year) attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claim Administrator. The names, addresses and phone numbers of the health care Claim Administrators are listed in the **Plan information** section of this document.
- Each of your children who is unmarried, is a "qualifying relative" as defined in section 152(d) of the Code as determined without regard to subsection(d)(1)(B), does **not** share your residence for more than half the year, and:
  - will attain age 19* as of the close of the plan year or is younger; or
  - will attain age 25* as of the close of the plan year or is younger, and a full-time student (meaning the student is enrolled in courses for at least 5 months during the plan year) who is attending an accredited school or college. Upon request, you must provide proof of student status in writing to the Claim Administrator. The names, addresses and phone numbers of the health care Claim Administrators are listed in the **Plan information** section of this document.

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

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

  * Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. If the child gets married or obtains a full-time job, coverage generally will remain in effect through the end of the month in which this occurs.

To be an eligible dependent, your children must be either:

- Your natural children;
- Your legally adopted children (For purposes of coverage under the health care plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.);
- Your stepchildren; or

- A child permanently residing in your household for whom you are the legal guardian. You must provide proof of guardianship in writing to the Claim Administrator.

Eligible dependents also include an employee's domestic partner and/or his or her dependent children. To be eligible, the children of the domestic partner must meet all the qualifications of eligible dependent children as described in this section. Please note that not all HMOs cover domestic partners or their children. For more specific information, contact your HMO directly.

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

Eligible dependents must be U.S. citizens or legal residents.

Qualified Medical Child Support Orders

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 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. Contact the Plans Administration Committee to receive, free of charge, a detailed description of the procedures for a QMCSO.

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 the Benefit Service Center when you want to make changes to your coverage or coverage category as a result of a qualified status change.

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.

Coverage for your dependent children will end:

- The last day of the month in which they:
  - Become employed full time;
  - Get married;
  - Become eligible for coverage under any plan as employees; or
  - Cease to be "eligible dependents" as defined in the previous section of this Plan document.

Newborns/newly adopted children

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

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

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Benefit Service Center 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:

- Health Benefit Plan (domestic partner medical benefits are not available through some HMOs);
- Dental Benefit Plan;
- Health Care Spending Account, provided your domestic partner and eligible dependent child(ren) are considered tax dependents under section 152 of the Code (note: domestic partners who do not meet section 152 can not have their claims submitted for reimbursement into the Health Care Spending Account), as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Vision Benefit Plan.

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 **www.citigroup.net** or by calling the 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:

- You currently reside together and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment and intend to do so permanently;
- You have mutually agreed to be responsible for each other's common welfare;
- You are both at least 18 years of age and mentally competent to consent to contract;
- You are not related by blood to a degree of closeness that would prohibit marriage if you and your partner were of opposite sexes;
- 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
- You 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
- Satisfy all other qualifications of eligible dependent children as described above.

Your domestic partner and his or her unmarried children must be U.S. citizens or legal residents to qualify for coverage.

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 the 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 **Your contributions**. 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). You do not need to be enrolled in the vision care plan to enroll a dependent for vision care coverage.

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 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 qualified status change.	Coverage for yourself or your dependent(s) will begin on the date of the qualified status change, such as the date of your marriage or divorce, your biological child's birth date, or the date your adopted child was placed for adoption.

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 Spending Account — the coverages 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 qualified status changes. You must make any qualified status change-related changes to your coverage within 31 days of the event. See **Qualified status changes**.

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 qualified status change.
Vision care	The annual open enrollment period or within 31 days of a qualified status change.
Health Care Spending Accounts	The annual open enrollment period or within 31 days of a qualified status change.

Qualified status changes

The rules regarding qualified status changes apply to coverage elections you make for your medical, dental, vision care, and the health care spending account coverage. 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 qualified status change or other applicable event, as further explained below.

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

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

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

Consistency requirements

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

Effect on eligibility

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

Corresponding election change

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

Coverage & cost events

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

Coverage events

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.

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

Cost events

You must contact 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 qualified status change or other applicable event, whichever occurs first.

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.

Other rules

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

Family and Medical Leave Act: You may drop medical (including the Health Care Spending Account), dental, and vision care coverage midyear when you begin an unpaid leave, subject to the provisions of the Family and Medical Leave Act (FMLA). If you drop coverage or if you fail to make payments for 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 *before-tax* basis" for such events unless they involve a *tax* dependent. Thus, if you make a midyear change due to an event involving your 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 17, *Your Federal Income Tax,* for a discussion of the definition of a tax dependent. The publication is available at **www.irs.gov/formspubs/index.html**.

Changing your coverage status

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

Your contributions

Your contributions for medical, dental, and vision care are based on the plan chosen and the coverage category. Your medical contribution also depends on your total compensation and which total compensation band applies to you. The required employee contributions to the medical, dental and vision plans increase as compensation increases. The compensation bands for 2006 are shown in the table below. Contributions for your Health Care Spending Account are determined by your contribution amount and not by your compensation band.

Total compensation bands on which employee contributions for medical coverage are based:
$20,000 or less
$20,001 – $25,000
$25,001 – $40,000
$40,001 – $60,000
$60,001 – $80,000
$80,001 – $100,000
$100,001 – $150,000
$150,001 – $250,000
$250,000 +

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

With respect to the current plan year, total compensation consists of (a) the annual rate of regular base pay based on scheduled work hours, excluding any shift differentials, as of July 1 of the calendar year (the "Prior Year") which precedes the current plan year; (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any non-annual cash bonuses paid during the calendar year which precedes the Prior Year; and (d) any annual bonus earned during the calendar year which precedes the Prior Year and that is paid in cash or in the form of an equity award under the Core Capital Accumulation Program during such calendar year or the Prior Year.

For example, the total compensation for the 2006 plan year includes:

- Base pay annualized as of July 1, 2005 (excluding shift differentials);
- Commissions paid from January 1 – December 31, 2004;
- Cash bonuses paid from January 1 – December 31, 2004 (excluding any annual bonus); and
- 2004 annual bonus (paid in 2004 and/or 2005).

If you were hired or rehired on or after July 1, 2005, your total compensation is your annualized base pay as of your date of hire.

If you are a part-time employee, your total compensation will be calculated as follows:

- Hourly rate of pay as of July 1, 2005 × 52 weeks × the number of hours scheduled to work

For Smith Barney financial consultants

In your first year of employment, your total compensation is considered to be $60,000. If you earned more than $60,000 in a previous brokerage firm in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 wage reporting statement to your HR representative within 30 days of your hire date. Your medical contributions will also be based on the higher amount.

Note: Actual contribution amounts are shown on the annual enrollment worksheet, which is provided to all eligible employees during each Annual Enrollment period.

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

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 the Benefit Service Center.

If your domestic partner and his or her child(ren) qualify as your dependents under section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, your contributions for domestic partner medical, dental, and/or vision care coverage will be taken on a pre-tax basis. However, if your partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, you will pay for their medical, dental, and/or vision care 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 qualify as dependents for federal income tax purposes as described above, the cost of any medical, dental, and/or vision care 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 for federal income tax purposes as described above, your contributions for their medical, dental, and/or vision care coverage will be taken before taxes are withheld, and there are no tax implications for you.

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

To review the qualifications of a section 152 dependent, see IRS Publication 501 at **www.irs.gov/formspubs/index.html**.

Coordination of benefits

Coordination of benefits provisions apply to the Health Benefit Plan and the Dental Benefit Plan only and are described in this section.

All payments under these Plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication 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 the applicable Citigroup 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).

The following definitions apply to terms used in this section:

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

The Citigroup 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.

When 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.

When the Citigroup Plan is the secondary plan, benefits under the Citigroup Plan may be reduced. The Claim 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.

With regard to any governmental health care coverage provided during a military leave, any health care coverage provided under the Citigroup Plans (including any such coverage required under USERRA, COBRA or other law or under any Citigroup military leave policy) will be secondary to the governmental health care coverage.

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 becomes covered by Medicare after a COBRA election is made, your COBRA coverage will end.

No-fault automobile insurance

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

Facility of payment

When benefit payments that would have been made under a 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 Claim Administrator has the right to decide which facts are needed. The Claim Administrator may get the needed facts from or give them to any other organization or person. The Claim Administrator need not tell, or get the consent of, any person to do this. At the time a claim for benefits is made, the Claim Administrator will determine the information necessary to operate this provision.

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

Recovery provisions

Recovery provisions apply to the Health Benefit Plan and the Dental Benefit Plan and are described in this section.

Refund of overpayments

Whenever payments have been made by a 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, the covered person(s) must make a refund to the Plan in the amount paid in excess of the amount payable under the Plan and help the Plan obtain the refund from another person or organization.

If the covered person(s) or any other person or organization that was paid does not promptly refund the full amount, the Plan may reduce the amount of any future benefits 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 — will promptly reimburse the Plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdicts, or insurance proceeds received by the covered person (or by the legal representatives, estate, or heirs of the covered person) to the extent that medical benefits have been paid for or provided by the Plan to the covered person.

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

The covered person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the covered person agrees to notify the Plan Administrator if and when the covered person institutes a lawsuit or other action, or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party. The covered person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The covered person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other disability or health Plan maintained by Citigroup or its participating companies to the extent necessary to reimburse this Plan under the Plan's subrogation or reimbursement rights.

In order to secure the rights of the Plan under this section, the covered person hereby:

- Grants to the Plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by the covered person to the extent of all benefits provided in an effort to make the Plan whole; and
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage. The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.

The covered person will cooperate with the Plan and its agents and will:

- Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
- Provide any relevant information; and
- Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

If the covered person does not sign and deliver any such documents for any reason (including but not limited to the fact that the covered person was not given an agreement to sign or is unable or refused to sign), the Plan Administrator, in its sole discretion, may or may not advance benefits to the covered person under the Plan. If the Plan Administrator has advanced benefits, it has the right to subrogation and reimbursement whether or not the covered person has signed the agreement. The covered person shall not take any action that prejudices the Plan's right of reimbursement.

Subrogation

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

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

The covered person is obligated to cooperate with the Plan and its agents 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.

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

For any of the Plans, 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 last day of the month in which you retire, you die, or you otherwise cease to be eligible for coverage;
- 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; or
- Midnight of the last day of employment if your termination is due to gross misconduct.

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

- Midnight of the last day of the month in which your coverage terminates;
- The date you elect to terminate your eligible dependent's coverage (which termination must be in accordance with Plan terms and applicable law);
- The last day for which the necessary contributions are made;
- The date the eligible dependent(s) ceases to be eligible for coverage. In general, 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;
- The date the dependent is no longer eligible for coverage under a QMCSO; or
- Midnight of the last day of the month in which you become legally separated or divorced (this applies to coverage for your spouse or domestic partner).

You and your eligible covered dependents may be able to continue coverage under COBRA. See **COBRA** for more information.

Coverage when you retire

You could be eligible for retiree health care coverage if you are at least age 55 with at least 5 years of service when you leave Citigroup. For more information on eligibility for this coverage, contact the Benefits Service Center. You will be required to contribute to the cost of coverage.

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care plan coverage and participation in the Health Care Spending Account for up to 13 weeks, as long as you make the active employee contributions. After you have been disabled for 13 weeks, if you are still disabled and/

or long-term disability coverage is pending, your coverage will remain in effect and you will be billed for benefits.

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

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

Length of recognized Citigroup service as of week 52 from STD date	Medical continuation period after week 52 (the termination of your employment)
Less than two years	Six months
Two years to less than five years	Equal to length of service
Five years or more	As long as you are disabled or have not reached the maximum age limit to receive LTD benefits

At the end of the period, you may continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Dental coverage will continue for 52 weeks, including the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Vision care coverage will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA. The continuation period is considered part of the period of COBRA-continued coverage.

Health Care Spending Account participation will continue for the 13-week period of short-term disability, as long as you make the active employee contributions. You may then continue coverage through COBRA for the remainder of the calendar year.

*In the event LTD was not elected and/or preexisting condition causes a denial of LTD benefits, the schedule outlined will apply in those cases and the disability carrier will monitor the disability claim.

Coverage if you take a leave of absence

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

Continuing coverage during FMLA

The federal Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for serious illness, the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are eligible for FMLA, you may take up to a total of 13 weeks of leave each calendar year (except where state law mandates differently).

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

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 COBRA 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. You may be required to repay any contributions that were advanced to you for your leave period.

During an FMLA leave, you have access to the entire amount of your Health Care Spending Account annual election, less any prior reimbursements that you have received, as long as you continue to make your contributions during your leave of absence. If you stop making contributions, your participation in the Health Care Spending Account will terminate while you are on FMLA leave. In that case, you may not receive reimbursement for any health care expenses you incur after your coverage terminated.

If your Health Care Spending Account participation terminates during your leave, your Health Care Spending Account contributions will begin again if you return to work during the same year in which your leave began. You will have the choice of either resuming your contributions at the same level in effect before your FMLA leave or electing to increase your contribution level to “make up” for the contributions you missed during your leave. If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave. If you elect to make up contributions, then the amount available for reimbursement will be the same amount you could receive immediately before the leave. Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you may not use your Health Care Spending Account for expenses incurred during the period you did not participate.

Continuing coverage during military leave – Citigroup policy

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) in accordance with the terms and conditions of the Citigroup Military Leave Policy. The policy generally provides for paid leave and subsidized employer contributions to health care continuation coverage for the duration of your leave, and is more generous in many respects than what federal law currently requires of employers. For a copy of the policy, please see you@citigroup.

Continuing coverage during military leave – no Citigroup policy

In the event such policy expires or otherwise ceases to remain in effect, you are still entitled to continue coverage for you and your dependents under the Health Benefit Plan, the Dental Benefit Plan, the Vision Care Plan and the Health Care Spending Account for the length of your leave up to 24 months in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as long as you give Citigroup notice of your leave as soon as practicable (advance notice, if possible). Your payments would be on an after-tax basis.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the portion you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire amount (including both 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. The Plans Administration Committee may take other steps to administer the Plans in accordance with USERRA and the Department of Labor regulations thereunder.

If you are on military leave for less than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage, as your eligibility for COBRA will begin on the date your leave ends.

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

Coverage for surviving dependents

When an active employee dies, his or her surviving covered spouse and/or dependent children may be eligible for continued coverage.

- If the employee was not eligible for retiree health care coverage at the time of death, medical and dental coverage will continue for the surviving spouse and/or dependent children for six months at no cost. After the six-month period, they will be eligible to continue coverage through COBRA. The six-month period of continued coverage is considered part of the COBRA period.
- If the employee was eligible for retiree health care coverage at the time of death, the surviving spouse and/or dependent children will be eligible for retiree health care coverage on the same terms as a retired employee.

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-sponsored medical, dental, or vision care plans, 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-sponsored medical, dental, or vision care plans, 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-sponsored medical, dental, or vision care plans, 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-sponsored medical, dental, or vision care plans, 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 (60 days from the date coverage was lost), 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 dependent has an independent election right for COBRA coverage. For example, if there is a choice among types of coverage, each qualified dependent 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-sponsored medical, dental, or vision care plans, 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. Send the notice to:

If you're an employee of any Citigroup business
Citigroup Service Center P.O. Box 56710 Jacksonville, FL 32241-6710

When Citigroup is notified that one of these events has happened, Citigroup in turn will notify you that you have the right to 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 dependents will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage:

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

Electing COBRA

To elect or inquire about COBRA coverage, contact the 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 a minimum of 18 months if you lost group health coverage because of a termination of employment or reduction in hours. When the qualifying event is the death of the employee, the employee’s becoming entitled to Medicare benefits (under Part A, Part B or both), your divorce or legal separation, or a dependent’s child’s losing eligibility as a dependent child, COBRA continuation coverage is available for up to 36 months.

Additional qualifying events (such as your death, divorce, legal separation, or Medicare entitlement or your child’s loss of dependent status) may occur while the continuation coverage is in effect.

If you lost coverage because of a termination of employment or a reduction in hours, these events can (but do not always) result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You must 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 Rule for HCSA: Except as required by law, the duration of COBRA continuation coverage for the Health Care Spending Account will not extend beyond the plan year in which the qualifying event occurred.

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 dependents due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified dependent 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 dependent 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.

If you become entitled to Medicare: If you lose coverage (medical, dental, or vision care plan, or Health Care Spending Account) due to your termination of employment or reduction in hours and you become

entitled to Medicare less than 18 months before the qualifying event, your eligible 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 COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any person who elected COBRA for any of the following five reasons:

- 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 person who elected COBRA becomes covered — after the date COBRA is elected — under another group health plan (whether or not as an employee) that does not contain any applicable exclusion or limitation for any preexisting condition of that covered individual;
- The person who elected COBRA 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 Plans, 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 plans should be directed to:

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

Or you may call 1-800-422-7608.

Your HIPAA rights

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

HIPAA restricts the ability of group health plans to exclude coverage for 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, when you and your dependents no longer have Citigroup medical coverage, you must receive certification of your coverage from the medical plan in which you were enrolled. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

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

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

Your special enrollment rights

If you decline to enroll 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 qualified 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.

Your right to privacy and information security

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

respect to your health information. Please refer to the Plans' privacy notice for more information. You can obtain a copy of the notice by contacting the Benefits Service Center.

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

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

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

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

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

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

Claims and appeals

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

Medical	
• For all plans other than HMOs	Use one of the following forms available on Citigroup.net to file a claim for a covered out-of-network expense: • 301 — Aetna Claim Form (for ChoicePlans 100, 250, 500 and the Health Plan 2000 participants). • 302 — CIGNA Claim Form (for ChoicePlans 100, 250, 500 and the Health Plan 2000 participants). • 303 — UnitedHealthcare (for ChoicePlans 100, 250, 500, the Health Plan 2000 and Hawaii Plan participants). • 322 — BlueCross BlueShield (for ChoicePlans 100, 250, 500, the Health Plan 2000). • 323 — BlueCross BlueShield (Out-of-Area Plan). • Based on your business group you may obtain forms via the Web **www.citigroup.net/human_resources/form.htm** or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
• HMO participants	• Call your HMO for any claim-filing information.
Dental	
• MetLife Preferred Dentist Program (PDP)	• Use Form 304 — MetLife Dental Claim form available on **www.citigroup.net**. • Based on your business group you may obtain the form through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.
• CIGNA Dental Care DHMO	• There are no claim forms to file under this plan.
• Delta Dental	• Use Form 307 — Delta Dental of New York Claim form available on Citigroup.net to file an out-of-network expense.
Vision	• Call Davis Vision at 1-800-999-5431 or visit **www.davisvision.com**.

Health Care Spending Account (HCSA)	• If you do not use your Citigroup FlexDirect debit card, you can file a claim by using the HCSA Reimbursement Request Form. However, you may be asked to complete and return the Spending Account Substantiation Form 318 if ADP cannot substantiate a transaction applied to your Citigroup Flex Direct debit card. • Based on your business group you may obtain forms via the Web **www.citigroup.net/human_resources/form.htm** or through the Forms and LifeTimes option of ConnectOne at 1-800-881-3938.

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

- Medical, dental, and vision care claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.
- Health Care Spending Account claims must be filed by June 30 of the calendar year following the year in which the expense was incurred or, if a “grace period” applies, by the June 30 following the end of the “grace period.”.

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

Claims and appeals for UnitedHealthcare medical plans

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

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

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

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;

- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

If you have a question or concern about a benefit determination, you may informally contact Customer Service before requesting a formal appeal. If the Customer Service representative cannot resolve the issue to your satisfaction over the phone, you may submit your question in writing. However, if you are not satisfied with a benefit determination, you may appeal it as described here, without first informally contacting Customer Service. If you first informally contact Customer Service and later wish to request a formal appeal in writing, you should contact Customer Service and request an appeal. If you request a formal appeal, a Customer Service representative will provide you with the appropriate address of the Claim Administrator.

The Customer Service telephone number is shown on your ID card. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. If you are appealing an urgent care claim denial, contact Customer Service immediately.

UnitedHealthcare level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claim Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card.
- The date(s) of medical service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Claim Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claim Administrator in considering the claim; and that demonstrates the Claim Administrator's processes for ensuring proper, consistent decisions.

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 Claim Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claim Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

UnitedHealthcare level two appeal

If you are not satisfied with the first level appeal decision of the Claim Administrator, you have the right to request a second level appeal from the Claim Administrator. Your second level appeal request must be submitted to the Claim Administrator within 60 days from receipt of first level appeal decision.

For appeals of pre-service claims, the second level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of post-service claims, the second level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

UnitedHealthcare urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claim Administrator as soon as possible. The Claim Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for Aetna medical plans

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

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

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

Claim forms may be obtained at www.citigroup.net. These forms tell you how and when to file a claim.

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;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Appeals for Aetna medical plans

You will have 180 days following receipt of a claim denial to appeal the decision. You will be notified of the decision no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claim Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

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 Claim Administrator.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Health Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your identification card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you and your authorized representative and the Claim Administrator by telephone, fax, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received. If you are dissatisfied with the appeal decision, you may file a second level appeal within 60 days of receipt of the level one appeal decision. The appeal will be handled in the same timeframes as the first level appeal and a notice will be sent to you explaining the decision.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claim Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You must exhaust the applicable level one and level two processes of the appeal procedure before you contact the Department of Insurance to request an investigation of a complaint or appeal; or file a complaint of appeal with the Department of Insurance; or establish any litigation; or arbitration; or administrative proceeding; regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the appeals procedure.

External Review

An "External Review" is a review by independent physician, with appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity or the experimental or investigational nature of a proposed service or treatment.

You may, at your option, obtain External Review of a claim denial provided the following are satisfied:

- You have exhausted the Aetna appeal process for denied claims, as outlined in this ***Claims and appeals for Aetna medical plans*** section of this document and you have received a final denial;
- The appeal is made by the member of the member's authorized representative.

- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue for which the member is financially responsible exceeds $500.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna the External Review Request Form (except under expedited review as described below), a copy of the plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted in writing to Aetna within 60 calendar days after you receive the final decision on your internal appeal.

Aetna will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision with 30 calendar days of Aetna's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the plan, except where Aetna or the plan can show reviewer conflict of interest, bias, or fraud. In such cases, notice will be given to you and the matter will be promptly resubmitted for consideration by a different reviewer.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review Form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30-calendar-day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within five calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna. Aetna is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

Your may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

Claims and appeals for CIGNA medical plans

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

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

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

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;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

The CIGNA medical plans have a two-step appeals procedure for coverage decisions. To appeal the denial of a claim, you must submit a request for an appeal in writing to CIGNA within 180 days after receiving notice of the denial of your claim. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask CIGNA to register your appeal by calling the toll-free number on your CIGNA HealthCare ID card. You may also register your appeal by an arranged appointment or walk-in interview.

You may submit written comments, documents, records, and other information relating to your claim, whether or not the comments, documents, records, or information were submitted in connection with the initial claim. You may also request that the Claim Administrator provide you, free of charge, copies of all documents, records, and other information relevant to the claim.

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 Claim Administrator. If the decision on review is not received within such time, the claim shall be deemed denied on review.

CIGNA level one appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving medical necessity or clinical appropriateness will be considered by a health care professional.

For level one appeals, CIGNA will respond in writing with a decision within 15 calendar days after receiving an appeal for a pre-service or concurrent coverage determination, and within 30 calendar days after receiving an appeal for a post-service coverage determination. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

CIGNA level two appeal

If you are dissatisfied with the level one appeal decision, you may request a second review. To initiate a level two appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the 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 medical necessity or clinical appropriateness, the committee will consult with at least one physician in the same or similar specialty as the care under consideration, as determined by the CIGNA Medical Director. You may present your situation to the committee in person or by conference call.

For level two appeals CIGNA will acknowledge in writing that your request was received and will schedule a committee review. For pre-service and concurrent care coverage determinations the committee review will be completed within 15 calendar days; for post-service claims, the committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, CIGNA will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information

needed by the Appeal Committee to complete the review. You will be notified in writing of the Appeal Committee's decision within five business days after the committee meeting, and within the committee review time frames above if the Appeal Committee does not approve the requested coverage.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

You may request that the appeal process be expedited if:

- the time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or
- your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

The CIGNA Medical Director, in consultation with the treating physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

CIGNA independent review procedure

If you are not fully satisfied with the decision of CIGNA's level two appeal review regarding your medical necessity or clinical appropriateness issue, you may request that your appeal be referred to an independent review organization. The independent review organization is composed of persons who are not employed by CIGNA HealthCare or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan.

Generally, there is no charge for you to initiate this independent review process. However, you must provide written authorization permitting CIGNA to release the information to the independent reviewer selected.

CIGNA will abide by the decision of the independent review organization.

For more information about CIGNA's independent review procedure, contact CIGNA. You may also contact your state's Department of Insurance for assistance.

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the CIGNA appeals procedure. You may not initiate a legal action against CIGNA until you have completed the level one and level two appeals processes.

Claims and appeals for Empire BlueCross BlueShield medical plans

Appeal filing deadlines

Action	Expedited Appeal	Prospective Standard Appeal	Retrospective Appeal
You may appeal to Empire BlueCross BlueShield, in writing (for an urgent care claim: orally or in writing)	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified	Within 180 calendar days after the date you were notified
Empire BlueCross BlueShield will notify you about the appeal decision	Within 72 hours after appeal is received	Within 15 calendar days after appeal is received	Within 30 calendar days after appeal is received
You can make a second appeal to Empire BlueCross BlueShield, in writing	N/A	Within 60 calendar days after appeal denial is received	Within 60 calendar days after appeal denial is received
Empire BlueCross BlueShield will notify you about the second appeal decision	N/A	Within 15 calendar days after appeal is received	Within 30 calendar days after appeal is received

Timing of initial claim approval or denial

The time within which your claim will be approved or denied will depend on the type of claim you file.

- **For claims involving urgent care,** you will be notified of the approval or denial no later than 72 hours after your claim is received. If your claim did not include enough information to determine whether it should be approved or denied, you will be notified within 24 hours after receiving your claim of the specific information that is necessary. You will have at least 48 hours to provide the specified information. You will be notified of the approval or denial no later than 48 hours after Empire BlueCross BlueShield receives the information or 48 hours after the deadline for providing the information, if earlier. For purposes of these claims procedures, urgent care means medical care or treatment that must be provided without delay to avoid seriously jeopardizing life, health or the ability to regain maximum function, or that must, in the opinion of a physician, be provided without delay to adequately manage severe pain.
- **For medical care requiring pre-certification approval (called a "pre-certification claim"),** you will be notified of the approval or denial of your claim no later than 15 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 15-calendar day period to 30 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 15-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to reach a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.

- For care involving an ongoing course of treatment to be provided over a period of time or through a number of treatments (called "concurrent care decisions"), you will be notified in advance of any decision by Empire BlueCross BlueShield to reduce or terminate the course of treatment that would be covered, so that you will have enough time to appeal the decision and receive a determination before the treatment is reduced or terminated. If you wish to extend the course of treatment and the treatment involves urgent care, you will be notified within 24 hours after your claim is received, as long as you make your claim at least 24 hours before the approved course of treatment is scheduled to end.
- **For all other care (e.g., reimbursement for medical services already received),** you will be notified of the approval or denial of your claim no later than 30 calendar days after your claim is received. Empire BlueCross BlueShield may extend this 30-calendar day period to 45 calendar days if it needs more time to review your claim due to matters outside of its control. If a longer period of time is required, you will be notified within the initial 30-calendar day period of the reasons for the extension and the date by which a decision will be made. You will be notified if your claim did not include enough information to make a decision. You will have at least 45 calendar days from receipt of the notice to provide the specified information.

Contents of claim denial notice. If you receive notice that your claim has been denied, either in full or in part, the claim denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a description of any additional material or information Empire BlueCross BlueShield requires and an explanation of why it is necessary
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement that you have the right to bring a civil action under Section 502(a) of ERISA but only after you have followed the Plan's claims procedures
- if an internal rule, guideline or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline or protocol, or a statement that it will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

First appeal to Empire BlueCross BlueShield. You have 180 calendar days after receipt of the denial to file an appeal with Empire BlueCross BlueShield. Your appeal must be in writing, except that an appeal of an urgent care claim may be made orally or in writing. Be sure to explain why you think you are entitled to benefits, and attach any documentation that will support your claim.

Approval or denial of appeal. Empire BlueCross BlueShield will send you its decision within the following deadlines: 72 hours for urgent care claims; 15 calendar days for pre-certification claims; and 30 calendar days for all other claims.

If your claim is based on a medical judgment, in reviewing your appeal, Empire BlueCross BlueShield will consult with a health care professional that has appropriate training and experience in the field of medicine involved in the medical judgment and will provide you with the name of the health care professional, upon request.

If Empire BlueCross BlueShield denies your appeal, the denial notice will include:

- the specific reasons for the denial
- reference to the specific Plan provisions on which the denial is based
- a statement that you have the right to bring a civil action under Section 502(a) of ERISA after you have followed the Plan's claims procedures and received an adverse decision on your first appeal (in the case of an urgent care claim) or on your second appeal (in the case of all other claims)
- if an internal rule, guideline or protocol was relied on in making the adverse determination, either a copy of the specific rule, guideline or protocol, or a statement that it will be provided on request, free of charge
- if the denial is based on a medical necessity exclusion, experimental treatment exclusion or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, or a statement that an explanation of the scientific or clinical judgment for the determination will be provided on request, free of charge.

Second appeal to Empire BlueCross BlueShield. For claims other than urgent care claims, if Empire BlueCross BlueShield denies your appeal, you have 60 calendar days from receiving the appeal denial to send a second appeal to Empire BlueCross BlueShield. Your appeal must be in writing. Empire BlueCross BlueShield will send you its written decision within 15 calendar days for pre-certification claims and 30 calendar days for all other claims.

If you are appealing an urgent care claim, Empire BlueCross BlueShield's decision on your first appeal will be final.

Authorized representative. If you appeal an adverse decision to Empire BlueCross BlueShield or the Medical Review Board, you may have an authorized person represent you (at your own expense). You have the right to examine the relevant portions of any documents that Empire BlueCross BlueShield referred to in its review.

Legal action. You must follow these claims procedures completely, which require one appeal to Empire BlueCross BlueShield for urgent care claims and two appeals to Empire BlueCross BlueShield for all other claims, before you can take legal action. After you receive the final decision from Empire BlueCross BlueShield, you can take legal action.

Claims and appeals for Express Scripts (the non-HMO prescription drug program)

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

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

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

Claim forms may be obtained at www.express-scripts.com. These forms tell you how and when to file a claim.

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;
- The procedure for further review of your claim; and
- A statement explaining your right to bring a civil action under section 502(a) of ERISA after exhaustion of the plan's appeals procedure.

Express Scripts level one appeal

If you disagree with a claim determination after following the above steps, you can contact the Claim Administrator in writing to formally request an appeal. Your first appeal request must be submitted to the Claim Administrator within 180 days after you receive the claim denial.

During the 180-day period, you may review any pertinent documents and information relevant to your claim, if you make a request in writing. This material includes all information that was relied on in making the benefit determination; that was submitted to, considered, or generated by the Claim Administrator in considering the claim; and that demonstrates the Claim Administrator's processes for ensuring proper, consistent decisions.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claim Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent medical claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

You will be provided written or electronic notification of decision on your appeal as follows:

- For appeals of pre-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.
- For appeals of post-service claims, the first level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claim Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Express Scripts level two appeal

If you are not satisfied with the first level appeal decision of the Claim Administrator, you have the right to request a second level appeal from the Claim Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claim Administrator within 60 days from receipt of first level appeal decision.

For pre-service and post-service claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Express Scripts urgent claim appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations the appeal does not need to be submitted in writing. You or your physician should call the Claim Administrator as soon as possible. The Claim Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

For urgent claim appeals, Citigroup has delegated to the Claim Administrator the exclusive right to interpret and administer the provisions of the Plan. The Claim Administrator's decisions are conclusive and binding.

Claims and appeals for MetLife PDP

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

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

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

You have the right to request a reconsideration of the denied claim by calling or writing MetLife. Any additional information that you feel would support the claim should be provided to MetLife.

If after the review it is determined that the initial denial can be reversed and claim paid, normal processing steps are followed. If after the review it is determined that the original denial stands, a denial letter is written.

Responses to an appeal are conducted by an individual of higher authority than the person who originally denied the claim. The response includes:

- Explanation of why the charges are denied in plain language
- Reference to the plan (booklet) wording which justifies the denial

The appeal request must be submitted in writing to MetLife within 180 days of receipt of the denial letter. As part of this review, you or your legal representative has the right to review all pertinent documents and submit issues and comments in writing to a committee selected by MetLife. The committee consists of senior representatives of MetLife Dental Claim Management and a Dental Consultant.

For pre-service and post-service claim appeals, Citigroup has delegated to MetLife as Claim Administrator the exclusive right to interpret and administer the provisions of the Dental Benefit Plan. The Claim Administrator's decisions are conclusive and binding. Please note that the Claim Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your physician.

Claims and appeals for the CIGNA Dental Care DHMO

If you have a concern about your Dental Office or the CIGNA Dental Plan, you can call 1-800-367-1037 toll-free and explain your concern to a Member Services Representative. You can also express that concern to CIGNA Dental in writing. Most matters can be resolved with the initial phone call. If more time is needed to review or investigate your concern, CIGNA Dental will get back to you as soon as possible, usually by the end of the next business day, but in any case within 30 days.

If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

CIGNA Dental has a two-step appeals procedure for coverage decisions. 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. 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 appeal by calling 1-800-397-1037.

CIGNA Dental level one appeal

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.

If your appeal concerns a denied pre-authorization, CIGNA Dental will respond with a decision 15 calendar days after your appeal is received. For appeals concerning all other coverage issues,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.

CIGNA Dental 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.

CIGNA Dental 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.

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

CIGNA Dental 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 review organization. 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 receipt of your level two decision. 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.

Claims and appeals for Delta Dental

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

Type of claim	Timeline after claim is filed
Post-service claims (for claims filed after the service has been received)	Decision within 30 days; one 15-day extension (notice of the need for an extension must be given before the end of the 30-day period.) Notice that more information is needed must be given within 30 days. You have 45 days to submit any additional information needed to process the claim.*
Pre-service claims (for services requiring precertification of services)	Not applicable. Delta does not condition the receipt of a benefit, in whole or in part, upon approval of the benefit in advance of obtaining dental care.
Urgent care claims (for services requiring precertification of services where delay could jeopardize life or health)	Usually not applicable. Urgent care claims do not ordinarily arise in the context of a fee-for-service plan involving dental care, such as Citigroup's dental plan. However, Delta Dental will comply with Department of Labor requirements for urgent care claims if any arise.
Concurrent care claims (for ongoing treatment)	Not applicable. Concurrent care claims do not occur in the context of a fee-for-service dental plan.

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

If a claim is denied in whole or in part, the claimant will receive a notice of payment or action that outlines the specific reason(s) and the specific plan provision(s) on which the determination was based. Upon request and free of charge, Delta will provide the claimant a copy of any internal rule, guideline or protocol, and/or an explanation of the scientific or clinical judgment if relied upon in denying the claim.

If the claimant or his/her attending dentist wants the denial of benefits reviewed, the claimant or his/her attending dentist must write to Delta **within one hundred eighty (180) days of the date on the Notice of Payment or Action. Failure to comply with such requirements may lead to forfeiture of the claimant's right to challenge the denial, even when a request for clarification has been made.**

The claimant's letter should state why the claim should not have been denied. Also, any other documents, data, information or comments that are thought to have bearing on the claim including the denial notice, should accompany the request for review.

The claimant or his/her attending dentist is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the denied claim. The review will take into account all comments, documents, records, or other information, regardless of whether the information was submitted or considered initially.

The review will be conducted for Delta by a person who is neither the individual who made the claim denial that is the subject of the review, nor the subordinate of the individual. If the review of a claim denial is based in whole or in part on a lack of dental necessity, experimental treatment, or a clinical judgment in applying the terms of the contract, Delta will consult with a dentist who has appropriate training and experience in the pertinent field of dentistry who is neither the Delta dental consultant who made the claim denial nor the subordinate of the dental consultant. The identity of the dental consultant will be available upon request whether or not the advice was relied upon. In making the review, Delta will not afford deference to the initial adverse benefit determination.

If after review, Delta continues to deny the claim, Delta will notify the claimant or his/her attending dentist in writing of the decision on the request for review within thirty (30) days of the date the request is received. Delta will send the claimant or his/her attending dentist a notice, similar to this notice. If in the opinion of the claimant or his/her attending dentist, the matter warrants further consideration, the claimant should advise Delta in writing as soon as possible.

The matter will be immediately referred to Delta's Dental Affairs Committee. This stage can include a clinical examination, if not done previously, and a hearing before Delta's Dental Affairs Committee if requested by the claimant or his/her attending dentist.

The Dental Affairs Committee will render a decision within thirty (30) days of the claimant's request for further consideration. The decision of the Dental Affairs Committee will be final insofar as Delta is concerned. Recourse thereafter would be to the state regulatory agency, a designated state administrative review board or to the courts with an action under section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA) or other civil action.

Claims and appeals for the Vision Benefit Plan

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

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

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

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

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

Claims include but are not limited to the following:

- Benefit denials;
- An adverse determination as to whether a service is covered pursuant to the terms of the contract;

- Difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services;
- Challenges with provided vision care services or products received; and
- Dissatisfaction with the resolution of a grievance, "adverse determination."

You may file a grievance by

- contacting Davis Vision's toll free hot line 24 hours a day at 1-800-584-1487;
- sending a letter via U.S. mail or overnight delivery; or
- logging on to the Web site: **www.davisvision.com**.

Written grievances should be sent to:

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

A written grievance will be acknowledged within five business days.

Davis Vision level one appeal

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

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

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

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

- Outcome of the investigation and a summary of the material facts related to the issue;
- Criteria that were utilized and a summary of the evidence, including the documentation supporting the decision;
- Statement indicating that the decision will be final and binding unless you appeal in writing to the Quality Assurance/Patient Advocate Department within 15 business days of the date of the notice of the decision;

- Copy of the appeals process, if applicable; and
- Name, position, phone number and department of the person(s) who was responsible for the outcome.

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

Davis Vision level two appeal

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

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

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

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

Davis Vision has 30 days, or as required by state statue, from the date the requested information is received, to respond to the level two review, or 45 days, or as required by state statute, if it is a post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the level one decision. If the level two appeal upholds the level one determination you will be notified in writing within 5 days.

Notification will include, but may not be limited to:

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

External review

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

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

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

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

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

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

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

Claims and appeals for the Health Care Spending Account

If you are denied a benefit under the Health Care Spending Account, you should proceed in accordance with the following procedures.

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

Step 2:*Review your notice carefully.* Once you have received your notice from ADP, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim

Step 3:*If you disagree with the decision, file an appeal.* If you do not agree with ADP's decision, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. You should file your appeal with ADP at the address provided below. You should submit all information identified in the notice of denial as necessary to perfect your claim and any additional information that you believe would support your claim.

ADP Claim Appeals
P.O. Box 1801
Alpharetta, GA 30023-1801

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

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

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

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

Citigroup Inc.
Plans Administration Committee
125 Broad Street, 8th Floor
New York, NY 10004

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Claim Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures, however, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Health Care Spending Account.

Administrative information

This section contains general information about the administration of the Citigroup Plans, the plan documents, sponsors, and Claim 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 and plan amendments

Citigroup has the right to amend, modify, suspend, or terminate any Plan, in whole or in part, at any time for any reason without prior notice. Citigroup may make any such amendment, modification, suspension, or termination of the plans for any reason. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements. The Plans are subject to various legal requirements, which may require changes in the Plans.

In the event of the dissolution, merger, consolidation or reorganization of Citigroup, the Plans will terminate unless the Plans are continued by a successor to Citigroup.

If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law.

No right to employment

Nothing in this document represents or is considered an employment contract, and neither the existence of the Plans nor any statements made by or on behalf of Citigroup shall be construed to create any promise or contractual right to employment or to the benefits of employment. Citigroup or you may terminate the employment relationship without notice at any time and for any reason.

Plan administration

The Plan Administrator is responsible for the general administration of the Plans, and is the "named fiduciary" under ERISA for each of the Plans. The Plan Administrator will be the Plan fiduciary to the extent not delegated to a Claim Administrator pursuant to an agreement or other document or arrangement. The Plan Administrator and, where delegated, the Claim Administrators have the exclusive discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits, including the power and discretion to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plans, and to remedy ambiguities, inconsistencies or omissions, and such determinations shall be binding on all parties.

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

- To administer and manage the Plans including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plans; and

- To act as Claim Administrator and to review claims and claim denials under the Plan to the extent another insurer or administrator is not empowered with such responsibility.

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

Funding and payment policy

Benefits under the Health Benefit Plan and the Dental Benefit Plan may be funded from the general assets of Citigroup, a trust qualified under section 501(c)(9) of the Internal Revenue Code, or under insurance contracts. The Vision Benefit Plan is fully insured, and the Health Care Spending Account is funded from general assets of Citigroup. The costs of the Health Benefit Plan, the Dental Benefit Plan, and the Vision Care Plan are shared between Citigroup and the plan participants. The cost of the Health Care Spending Account is generally borne by the participants. Any refund, rebate, dividend adjustment or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses. All Plan assets shall be used to pay benefits under the Plans or pay the reasonable expenses of Plan administration. Payments under the Plans shall be made in accordance with Plan terms, insurance policies, or administrative agreements.

Compliance with law

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

Plan information

Employer Identification Number	52-1568099
Participating Employers	Citigroup Inc. and any of its [U.S.] subsidiaries in which at least an 80% interest is owned.
Plan Names and Numbers	
• Medical plans (self-funded ChoicePlans, Health Plan 2000, Hawaii Health Plan, Out-of-Area Plan, and HMOs) including prescription drugs	Citigroup Health Benefit Plan Plan number 508
• Dental plans	Citigroup Dental Benefit Plan Plan number 505
• Vision care plan	Citigroup Vision Benefit Plan Plan number 533
• Health Care Spending Account	Citigroup Flexible Benefits Plan Plan number 512

Plan Administrator	Plans Administration Committee of Citigroup Inc. 125 Broad Street, 8th Floor New York, NY 10004
Plan Sponsor	Citigroup Inc. 75 Holly Hill Lane Greenwich, CT 06830

Claim Administrators

Each of the Claim Administrators has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of the Plans— namely, those provisions of the Plan document that apply to the participant and administered by that particular Claim Administrator.

ChoicePlans and Health Plan 2000	Aetna Citibank Claim Division P.O. Box 981106 El Paso, TX 79998-1106 1-800-545-5862 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
For fully insured HMOs	Call the Citigroup HMO Administrator at 1-800-422-6106

For self-insured HMO plans	Aetna P.O. Box 1125 Blue Bell, PA 19422 1-800-821-3808 CIGNA HealthCare P.O. Box 5200 Scranton, PA 18505-5200 1-800-794-4953 or P.O. Box 182223 Chattanooga, TN 37422-7223 UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845 Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940
Hawaii Health Plan	UnitedHealthcare P.O. Box 740800 Atlanta, GA 30374-0800 1-877-311-7845
Out-of-Area Plan	Empire BlueCross BlueShield P.O. Box 5072 Middletown, NY 10940-9072 1-866-290-9098
For Prescription Drug Program	
• Retail Pharmacy	Express Scripts Health Prescription Solutions, Inc. P.O. Box 2187 Lee's Summit, MO 64063-2187
• Express Scripts By Mail	Express Scripts, Inc. Home Delivery Services P.O. Box 510 Bensalem, PA 19020-0510
For Dental Plans	
• MetLife 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
• Delta Dental	Delta Dental One Delta Drive Mechanicsburg, PA 17055 1-800-932-0783
For Vision Care Plan	Davis Vision 159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U
For Health Care Spending Account	ADP Claims Processing Center P.O. Box 1800 Alpharetta, GA 30023-1800 1-800-378-1823 Fax: 678-762-5693
Agent for Service of Legal Process	Citigroup Inc. General Counsel 399 Park Avenue, 3rd Floor New York, NY 10043
Plan Year (for all Plans)	January 1 — December 31
Type of Administration	The plans are administered by the Plans Administration Committee through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators. The Claim 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.

Citigroup Vision Benefit Plan

Amended and Restated as of January 1, 2006

Citigroup Vision Benefit Plan

Introduction

This plan document sets forth the terms and conditions of your benefits under the Citigroup Vision Benefit Plan (the "Plan"), as amended and restated as of January 1, 2006. Citigroup has entered into an arrangement with Davis Vision to administer the Vision Benefit Plan.

This document should be read in combination with the **About Your Health Care Benefits** document, amended and restated as of January 1, 2006, which is also a component of the Citigroup Vision Benefit Plan. As explained in more detail in that document, Citigroup reserves the right to amend or terminate the Plan at any time.

This section of the document 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.

Overview

The Vision Benefit Plan offers you and your eligible dependents a variety of vision care services and supplies.

Please be advised that when you make your election to enroll in the Vision Benefit Plan, it is on an annual basis. You can change your election only if you have a **qualified status change**. You do not have to be enrolled in the Vision Benefit Plan to cover a dependent.

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

Network benefit	Coverage
Eye examination	• Covered at 100% – one exam per calendar year.
Frames and lenses	• Covered at 100% – one pair of frames and lenses per calendar year. • Must be selected from the network-provided frames Davis Vision's Exclusive "Tower Collection". • $50 wholesale allowance toward retail frame purchases outside of the "Tower Collection" or an equivalent retail allowance at a retail chain. • 20% discount on additional pairs of glasses at a network provider.
Contact lenses (in lieu of glasses)	• One pair of standard, soft, daily-wear contact lenses covered at 100% per calendar year in lieu of eyeglasses, or • An initial dispense of Davis Vision supplied disposable/ planned replacement contact lenses covered at 100% – in lieu of eyeglasses. (An initial dispense includes a four-box supply (four multipacks) for disposable contact lens wearers.), or • A $105 allowance towards contact lenses from the provider's private supply (such as toric and gas permeable).
Laser vision correction (Lasik)	• Up to 25% discount off reasonable and customary fees, or 5% discount off any advertised (discounted) fee when using one of Davis Vision's participating laser surgeons. Some centers have flat fees equivalent to these discounts.
Broken eyewear (frames, materials)	• Davis Vision Collection frames are covered by an unconditional one-year warranty.
Maximum benefit	• Benefit that has been paid in full except for defined copayments.

Out-of-network benefit	Coverage
Frames/lenses including eye examination **OR** **Contact lenses including eye examination**	• Examination; up to $30 • Frame; up to $50 • Single vision lenses up to $25, bifocal up to $35, trifocal up to $45 and lenticular up to $60 • Contact lenses; up to $75 • Medically necessary contact lenses; up to $225

Network services

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

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

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

Using network services

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

- To locate a network provider, visit Davis Vision at **www.davisvision.com** or call 1-800-999-5431. If you are enrolled in the program, enter the employee's Social Security number. **If you are not currently enrolled in the program or are going through open enrollment, please access the open enrollment feature through the Davis Vision Web site (www.davisvision.com) and enter Member ID/Control Code number 2227. Or you may call Davis Vision during your enrollment period at 1-877-92-DAVIS.** (TDD services are available by calling 1-800-523-2847.) An automated Voice Response Unit (available 24 hours a day, seven days a week) or one of Davis Vision's Member Service Representatives (available Monday through Friday, 8:00 a.m. to 11:00 p.m., Saturday, 9:00 a.m. to 4:00 p.m., and Sunday, 12 p.m. to 4 p.m. Eastern Time) will assist you. Once you are enrolled, you can call Davis Vision at 1-800-999-5431 to verify your eligibility.
- Call a network provider to schedule an appointment. Claim forms are not required.
- Provide the doctor with the Citigroup employee's Social Security number. If you're calling for services for your covered dependent, you'll need to provide your dependent's date of birth.
- A full listing of network providers is available free of charge by calling Davis Vision at 1-800-999-5431 or visiting them at www.davisvision.com.

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

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

Please note that if you join the Vision Benefit Plan, no identification card is necessary.

Types of coverage

The Davis Vision network offers three different types of coverage: eye examinations, eyeglasses (frame and lenses), or contact lenses in lieu of eyeglasses.

Eye exams

Covered employees and dependents are eligible to receive a comprehensive eye examination from a network provider once in each 12-month period, based on the calendar year.

Eyeglasses (frame and lenses)

Covered employees and dependents are eligible to receive a complete pair of eyeglasses (frame and lenses) once in each 12-month period based on the calendar year. You may select contact lenses instead of eyeglasses for most prescriptions.

A full selection of frames and lenses from The Collection should be available from most network providers. In the event that The Collection is not displayed, ask the provider for the full selection of Davis Vision frames. When receiving services from a provider who does not have The Collection (such as a participating retail chain), you will receive a retail credit comparable to the $50 wholesale allowance which will be applied to your purchase.

You may select many types of lenses at no additional cost to you, including:

- Plastic or glass single vision, bifocal or trifocal lenses;
- Glass grey #3 prescription sunglasses;
- Oversized lenses;
- Fashion, sun or gradient tinted plastic lenses;
- Postcataract (lenticular) lenses;
- Intermediate vision lenses;
- Polycarbonate lenses;
- Progressive addition multifocals* (including Varilux™);
- Photogrey Extra® (sun-sensitive) glass lenses;
- Ultraviolet coating;
- Blended invisible bifocals; and
- Scratch resistant coating.

* Progressive addition multifocals can be worn by most people, but not all. Conventional bifocals will be supplied to anyone who is unable to adapt to progressive addition multifocals.

When you go to a network provider, the following optional lens features are available at fixed, discounted prices:

Optional lens feature	Discounted price
Standard anti-reflective coating	$35.00
Premium anti-reflective coating	$48.00
Polarized lenses	$75.00
High-index lenses	$55.00
Plastic photosensitive lenses	$65.00

Contact lenses

You may select contact lenses (either standard, soft, daily-wear or disposable/planned replacement contacts) instead of eyeglasses for most prescriptions. The Vision Benefit Plan provides an initial supply of either standard, soft, daily-wear or disposable/planned replacement contact lenses. There is no copayment for plan covered lenses. Your provider will give you the specific copayment information for the type of lenses you require.

- New or current contact lens wearers will receive four boxes of disposable type lenses. You will also receive a care kit for proper cleaning and sterilization of your lenses, as well as all necessary visits for proper fitting.

If you are not able to be fit by Plan-covered lenses you will receive a retail credit of $105 toward other types of contact lenses (i.e., toric lenses, gas permeable lenses, etc.) that aren't available through Davis Vision.

Employees who seek services through a participating retail location will also receive an allowance of $105 to be applied toward the cost of contact lenses from the retail location's supply.

Medically necessary contact lenses will be covered in full at all provider locations with prior approval.

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

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

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

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

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

Lasik

Davis Vision offers up to 25% off usual and customary fees for laser vision corretion, known as Lasik, or 5% off any advertised/discounted fee, whichever is lower, when using one of the surgeons from the Davis Vision network. Some providers charge flat fees equivalent to those discounts. Lasik surgeons are available across the country with accommodations for local pre-and post-operative care.

Participants who intend to have Lasik must go to the Davis Vision site at **www.davisvision.com** to obtain a confirmation number and then provide the confirmation number to the surgeon performing the laser correction.

The list of doctors and facilities performing laser vision correction surgery is different from the routine vision provider listing.

For more information about the network or to find a laser surgeon near you, please visit **www.davisvision.com** or call 1-877-923-2847. Enter Citigroup code 2227 for a list of participating providers.

Low Vision

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

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

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

Out-of-network services

You may use out-of-network providers for eye care services and submit a claim for reimbursement. When you visit an out-of-network provider, you must bring a Davis Vision claim form with you. Claims forms are available by visiting **www.davisvision.com** and going to "Information and Forms," or by calling 1-800-999-5431.

When you go to an out-of-network provider, the Vision Benefit Plan will provide reimbursement up to:

- Examination: $30; Frame: $50; Single vision lenses: $25; bifocal lenses: $35; trifocal lenses: $45; lenticular lenses: $60; or
- In lieu of eyeglasses (frame and lenses) you may receive reimbursement for contact lenses at $75 or medically necessary contact lenses (prior approval required) at $225.

Definition Of Medical Necessity

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

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

What is not covered

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

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

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

Other information

Other important information about the Vision Benefit Plan is summarized below:

Splitting of benefits

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

Travel and student coverage

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

Filing claims

See **Claims and appeals for the Vision Benefit Plan** for information about submitting claims and filing an appeal.