Expatriate Health and Insurance Benefits Enrollment Handbook

For Coverage Effective January 1, 2024

Contents

Introduction

This summary plan description (SPD) provides an overview of your benefits as an active employee while on an expatriate assignment.

It also describes the benefits available to you as an eligible retiree if:

- You are on an expatriate assignment when you retire and you choose to remain living outside of the United States, Puerto Rico or Canada; or
- You are an eligible Citi retiree who is actively enrolled in the Citigroup U.S. retiree benefit program and moves outside of the United States, Puerto Rico or Canada.

The benefits and programs described in this document are in effect as of January 1, 2024. The terms and conditions of the Plans noted below may be further described in insurance policies, the provisions of which, as may be amended from time to time, are hereby incorporated by reference.

How to Contact the Citi Benefits Center

For all expatriate benefit related questions, coverage changes (for example, to opt out of coverage, to or add or drop an eligible dependent), etc. contact the Citi Benefits Center and ask to speak with an expatriate benefit representative who can answer questions about your eligibility, enrollment, premium costs, coverage for dependents and spouses/partners and more.

- From outside the U.S., Puerto Rico, Canada or Guam: **+1 (469) 220-9600** and press 1 when prompted
- From within the U.S, Puerto Rico, Canada or Guam.: **+1 (800) 881-3938**
- From the ConnectOne “benefits” menu, choose the “health and insurance benefits” option. Representatives are available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

Benefits for Active Expat Employees

Citi provides a basic level of benefits coverage, called core benefits that are provided at no cost to you, as well as the opportunity to enroll in additional coverage for you and your family. Benefits coverage is effective at the start of your expatriate assignment. If you were newly hired in an expatriate assignment or if you were recently transferred to an expatriate assignment, you will automatically be enrolled in medical, dental and long-term disability (LTD) coverage. To have Group Universal Life (GUL) or Supplemental Accidental Death & Dismemberment (AD&D) coverage (together, the “Plans” or individually, the “Plan”), you are required to enroll. Be sure to read this entire section for details.

The Citi Expatriate Benefits use four Compensation Countries: Hong Kong, Singapore, the United Kingdom and the United States. The components of the benefits vary by Compensation Country, as outlined below. For the purpose of this Handbook, please note that all amounts are described in US dollars ($); the equivalent value in British Pounds (GBP), Hong Kong dollars (HKD) and Singapore dollars (SGD) applies where applicable.

Benefits Overview

	US($)	GBP	HKD	SGD	Enrollment information
Core Benefits – automatic enrollment					
Medical	X	X	X	X	Automatic enrollment; 90 days from date of transfer opt out period. All "newly eligible" and/or "new transferring" Expatriates and their eligible dependents are automatically enrolled. If you are already a participant, eligible dependents include those previously covered.
Dental	X	X	X	X	Automatic enrollment; 90 days from date of transfer opt out period. All "newly eligible"[1] and/or "new transferring" Expatriates and their eligible dependents are automatically enrolled. If you are already a participant, eligible dependents include those previously covered.
Short-Term Disability (core benefit)	X	N/A	X	X	This is a core benefit, no enrollment required.
Core Benefits at no cost to you (if eligible) – automatic enrollment					
Long-Term Disability	X	N/A	X	X	If eligible, this is a core benefit. For all others, automatic enrollment, as of Expatriate transfer date; 90 days from date of transfer opt out period.
Basic Life insurance (core benefit)	X	N/A	X	X	If eligible, this is a core benefit, no enrollment required.
Basic Accidental Death and Dismemberment (AD&D) insurance (core benefit)	X	X	X	X	If eligible, this is a core benefit, no enrollment required.
Business Travel Accident/Medical insurance (core benefit)	X	X	X	X	If eligible, this is a core benefit, no enrollment required

	US($)	GBP	HKD	SGD	Enrollment information
Optional Benefits – enrollment action required					
Group Universal Life (GUL) insurance	X	N/A	X	X	31 days from date of transfer if eligible. Enrollment is handled directly with MetLife and completed forms should be sent to them.
Supplemental AD&D insurance	X	X	X	X	31 days from date of transfer if eligible. Enrollment is handled directly with MetLife and completed forms should be sent to them.

All “newly eligible” and/or “new transferring” expatriates and their eligible dependents are automatically enrolled in the Citi Expatriate Medical and Dental Plans (the “Health Plans”).

If you are already a participant in the Health Plans, you will continue to have the same coverage that you and/or your eligible dependents had in 2024, and there is no need for you to re-enroll. Eligible dependents not previously covered can be added to coverage during Annual Enrollment or when you have a qualified change in status event. (Refer to the “Qualified Changes in Status” section.)

The required premiums of the Plans will be deducted automatically from your pay each month.

If you choose to remain enrolled in the Health Plans, you do not need to take any action. However, to ensure that your claims are processed correctly, you are advised to verify that you and your dependents’ information is displayed correctly on the confirmation of enrollment sent to your permanent address on file according to Citi’s records. You can also view this information by visiting Your Benefits Resources™ (YBR™) through My Total Compensation and Benefits at www.totalcomponline.com.

You can choose to opt out of (decline) coverage under either or both of the Health Plans within **90 days** of your transfer date (the automatic “auto” enrollment period) by calling the Citi Benefits Center via ConnectOne. If you decide to opt out of coverage within your initial 90-day following your automatic enrollment, you will receive a refund of premiums paid. If you elect to decline coverage under either or both of the Health Plans, Citi is not, and will not be liable or responsible for you and/or your eligible dependents’ health care expenses related to the declined coverage.

Changing your coverage under either or both of the Health Plans (which includes declining coverage) cannot be made after the 90-day period following your automatic enrollment unless you experience a qualified change in status (e.g., marriage, divorce, birth of a child, etc.) during the plan year. Otherwise, your next opportunity to change your coverage will be during a subsequent Annual Enrollment period. Changes will be effective January 1 of the following plan year.

You will receive an email from the Citi Benefits Center advising you how to access YBR™ through My Total Compensation and Benefits at www.totalcomponline.com to review your automatic enrollment. See “How to review your benefits online” for more information on accessing your personal benefits information.

Core Benefits

Core benefits, provided at no cost to you, consist of:

- **Basic Life insurance**: Equal to your benefits eligible pay (only for employees whose benefits eligible pay is less than US ($) 200,000 on their date of eligibility). Basic Life insurance is insured by MetLife. If your benefits eligible pay is equal to or exceeds US($) 200,000, you are not eligible for Basic Life insurance;
- **Basic Accidental Death and Dismemberment (AD&D) insurance**: Equal to your benefits eligible pay, (only for employees whose benefits eligible pay is less than US($) 200,000 on their date of eligibility). Basic AD&D insurance is insured by MetLife. If your benefits eligible pay is equal to or exceeds US($) 200,000, you are not eligible for Basic AD&D insurance;
- **Business Travel Accident/Medical (BTA/BTM) insurance:** Coverage is provided by Chubb. BTA coverage is equal to five times your benefits eligible pay to a maximum benefit of $2 million while traveling on behalf of Citi outside of your assigned country. Your spouse/partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip. An eligible spouse/partner has a coverage amount of $150,000. Each eligible dependent child (up to age 26) has a coverage amount of $25,000.
- **Short-Term Disability (STD) coverage**: Replaces up to 100% of your annual base salary for an approved disability leave of up to 13 weeks. The STD coverage is administered by MetLife; and
- **Long-Term Disability (LTD) coverage**: Equal to 60% of your benefits eligible pay, if your benefits eligible pay is less than or equal to US($) 50,000.99. The LTD coverage is administered by MetLife.

Optional Benefits

Optional benefits vary by Compensation Country. Please refer to the chart under "Benefits Overview" above for summary details.

A reminder about medical and dental coverage for newly eligible Expatriates:

You and your eligible family members will automatically be enrolled.

- If you want to opt out of coverage, you must do so during your initial 90-day auto enrollment period. You will receive a refund of premiums paid. After the initial 90-day coverage period, you are not permitted to decline medical and dental coverage.
- If you decide to opt out of the medical or dental coverage during your initial 90-day auto enrollment period and later decide you want coverage, you can enroll in coverage during a subsequent Annual Enrollment period, or as the result of a qualified change in status, such as getting married or having a baby.

No Pre-Existing Conditions Limitations

The Health Plans do not have a pre-existing condition limitation or exclusions that would prevent you from enrolling in the plans or receiving benefits for a specific condition or illness.

Medical

- Your medical contributions are based on the coverage category you select, and you can choose any doctor when you need medical care. You do not have to meet a deductible if you receive care outside the U.S. or if you use in-network providers in the U.S.
- A deductible applies to out-of-network coverage in the U.S. only.
- Aetna International representatives can refer you and your covered family members to medical professionals in most countries, and they can monitor the quality of the care you receive to help you and your covered family members manage an illness.
- Aetna International can reimburse your covered medical expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT), or wire the money directly to your bank account and will cover any applicable fees. Aetna International can also pay medical providers directly in a variety of currencies.
- Prescription drugs are covered the same as other medical expenses. Expatriates in the U.S. can also use the Aetna Rx Home Delivery, a home-delivery pharmacy service for maintenance medications.

Dental

- Your dental contributions are based on the coverage category you select, and you can choose any dentist you wish. You do not have to meet any deductible to be reimbursed for preventive and diagnostic services.
- When seeking dental care in the U.S., you can take advantage of Aetna International's in-network discounts, available in most states.
- Aetna International representatives can refer you and your covered family members to dental professionals in most countries.
- Aetna International can reimburse your covered dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT), or wire the money directly to your bank account and will cover any applicable fees. Aetna International can also pay dental providers directly in a variety of currencies.

Short-Term Disability (STD)

Short-Term Disability (STD) is a core benefit available to all benefits eligible employees. No enrollment is necessary. However, you must report all disabilities to the plan administrator before you can receive a benefit. To report a disability, call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or, call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "disability or FMLA related absences" option. You can also call MetLife, Citi's disability claims administrator, directly at **+1 (888) 830-7380**. STD pays up to 100% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks.

Long-Term Disability (LTD)

Long-Term Disability (LTD) benefits are provided through a MetLife group disability policy in the event you suffer a covered disability. You may be eligible to receive LTD benefits if you are approved for an STD benefit and your approved disability continues for more than 13 weeks. LTD coverage replaces 60% of your benefits eligible pay (pre-disability earnings) determined on the day before your approved STD ends. Your "pre-disability earnings" under the MetLife group disability policy constitutes your benefits eligible pay for purposes of LTD benefits.

LTD provides income replacement for as long as you are deemed disabled and entitled to benefits according to plan provisions.

If your benefits eligible pay is less than or equal to US($) 50,000.99, LTD is a core benefit provided at no cost to you. If your benefits eligible pay is US($) 50,001 or more, you will be automatically enrolled in LTD coverage on your expatriate transfer date, unless you were previously enrolled. You can elect to decline the LTD coverage. If you decline the automatic enrollment in LTD coverage within the initial 90-day coverage period after the automatic enrollment, you will receive a full refund of premiums paid. If you decline LTD coverage after the initial 90-day coverage, your premiums paid will not be refunded. To decline coverage, call the Citi Benefits Center. Please note: If you were previously enrolled in LTD coverage prior to your expatriate transfer date, you will not receive a refund of premiums if you decline the LTD coverage at that time. If you actively decline the LTD coverage and subsequently decide to enroll, you will be required to provide evidence of insurability to be considered for coverage unless your election is due to a qualified change in status.

Group Universal Life (GUL) Insurance

You can enroll in GUL insurance for you from one to 10 times your benefits eligible pay, not to exceed US($) 500,000, up to a maximum US($) 5 million. If your benefits eligible pay is not an even multiple of US($) 1,000, it will be rounded up to the next US($) 1,000. You can also enroll your spouse/partner and/or children in coverage.

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

If you are enrolling for the first time as newly eligible and you are enrolling (i) within your initial eligibility period of 31 days of your eligibility or transfer date or (ii) for an amount no greater than three times your benefits eligible pay (not exceeding US($) 500,000 or US($) 1.5 million), or(iii) as a result of a qualified change in status, you will not be required to provide evidence of good health by completing an evidence of insurability questionnaire or undergoing a physical exam. Please note if you are enrolling otherwise, you will be required to provide evidence of insurance and the increased amount of coverage will be effective upon approval by MetLife up to the maximum allowable amount.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

You can enroll in Supplemental AD&D insurance, provided by MetLife, from one to 10 times your benefits eligible pay, not to exceed US($) 500,000, up to a maximum coverage amount of US($) 5 million. If your benefits eligible pay is not an even multiple of US($) 1,000, your benefits eligible pay will be rounded up to the next US($) 1,000. Your cost is based on coverage you elect. If your benefits eligible pay is reduced, your Supplemental AD&D amount will continue to be based on the higher benefits eligible pay unless you call MetLife to request that the Supplemental AD&D amount be reduced.

Questions?

Call the HR Shared Services (HRSS) North America Shared Services Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option.

Benefits for Eligible Expat Retirees

When you retire and meet the Citi retiree benefits eligibility requirements, you may elect coverage under the Citi Expatriate Health plan for retirees (including medical, prescription drug and dental coverage) administered by Aetna International if:

- You are on an expatriate assignment when you retire and you choose to remain living outside of the United States, Puerto Rico or Canada; or
- You are an eligible Citi retiree who is actively enrolled in the Citigroup U.S. retiree benefit program and moves outside of the United States, Puerto Rico or Canada.

You will also have the opportunity to continue GUL insurance or Supplemental AD&D coverage by converting to an individual policy offered through MetLife. Be sure to read this entire section for details.

The Citi Expatriate Benefits use four Compensation Countries: Hong Kong, Singapore, the United Kingdom and the United States. The components of the benefits vary by Compensation Country, as outlined below. For the purpose of this Handbook, please note that all amounts are described in US dollars ($); the equivalent value in British Pounds (GBP), Hong Kong dollars (HKD) and Singapore dollars (SGD) applies where applicable.

Generally, if not automatically enrolled, you are required to elect coverage under the Plans within the time indicated in your enrollment package. If you decline Health Plan coverage after you are automatically enrolled, you will not be permitted to enroll at a later date unless there is a qualified change in status or during Annual Enrollment for the next plan year.

Benefits Overview

Medical

- Your cost for coverage will depend on the coverage category you choose as shown on your Personalized Enrollment Worksheet.
- You can choose any doctor when you need medical care.
- A deductible applies to out-of-network coverage received within the U.S. while travelling outside of your country of residence.
- Aetna International representatives can refer you and your covered family members to medical professionals in most countries, and they can monitor the quality of the care you receive to help you and your covered family members manage an illness.
- Aetna International can reimburse your covered medical expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT) or wire the money directly to your bank account and will cover any applicable fees. Aetna International can also pay medical providers directly in a variety of currencies.
- Prescription drugs are covered the same as other medical expenses. Expatriates in the U.S. can also use the Aetna Rx Home Delivery, a home-delivery pharmacy service for maintenance medications.

Dental

- Your cost for coverage will depend on the coverage category you choose as shown on your Personalized Enrollment Worksheet.
- You can choose any dentist you wish. You do not have to meet any deductible to be reimbursed for preventive and diagnostic services.
- Aetna International representatives can refer you and your covered family members to dental professionals in most countries.
- Aetna International can reimburse your covered dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT), or wire the money directly to your bank account and will cover any applicable fees. Aetna International can also pay dental providers directly in a variety of currencies.

Group Universal Life (GUL) Insurance

Your GUL coverage may be continued under an individual policy. MetLife will send you information regarding the continuation of your GUL coverage once notified of your retirement. If you continue your GUL coverage, MetLife will bill you directly at a higher rate than the Citi group insurance rate. The rate will become effective in the month following your termination of employment or transfer. If you have any questions on continuing your coverage, call MetLife directly at +**1 (888) 830-7380**.

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

If you retire from Citi, you and your spouse/partner and children may continue coverage by paying premiums directly to MetLife. If you continue coverage, MetLife will bill you at a higher rate than the Citigroup insurance rate effective the month following the loss of eligibility. If you have any questions on coverage continuation, call MetLife directly at +**1 (888) 252-3607**.

Questions?

Call the HR Shared Services (HRSS) North America Shared Services Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the “health and insurance benefits” option.

Health and Insurance Benefits for Active Expatriate Employees

Eligibility and Participation

This section of the SPD provides important information about eligibility, enrollment and participation in your Citi Expat health and insurance benefits.

Eligibility and Dependent Information

You are eligible to be enrolled in Expatriate benefits if you are classified as an Expatriate employee of Citi or a participating business. If eligible, your eligible dependents (defined below) will also be enrolled in the applicable plans tied to your compensation policy automatically.

If you want GUL or Supplemental Accidental Death and Dismemberment (if applicable to your compensation policy) insurance for you and/or your family, you will need to actively enroll.

You must be actively at work (not on an approved leave of absence) to enroll in GUL insurance, if applicable (if you have not previously enrolled for the maximum benefit) and Long-Term Disability (if you declined automatic enrollment and subsequently decided to enroll later). Other restrictions may apply.

A Note for Employees Who Were Involuntarily Terminated

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

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

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

If you are involuntarily terminated, and you are eligible for the retiree health plans on your termination date, you must choose between electing retiree health coverage, as currently available or continuing health coverage through COBRA. If you elect COBRA, you will not be able to elect retiree health coverage at a later date.

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

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

If you have questions about eligibility for retiree health plan coverage, call the Citi Benefits Center. If you have questions about plan benefits or claims, contact your insurance provider.

If Both You and Your Spouse/Partner Worked for Citi

If you and your spouse/partner were employed by Citi as expatriates, each of you may be covered under the Health Plans as either an employee or a dependent, but not both. You may enroll in the Health Plans cover both of you, or you may each enroll separately in the Health Plans. Either of you may cover your children, but they cannot be covered by both of you.

Definition of Eligible Dependents

You must provide proof of your dependents' eligibility for coverage if you are enrolling them in Citi plans for the first time ("newly added" dependents). Specifically, you will be prompted to submit the appropriate documentation, such as a copy of your government-issued birth certificate and marriage license, copies of passports/visas for each dependent, and/or tax return to ensure your newly added dependents' coverage is not canceled and their claims are paid.

Note: The "common law marriage," referred to below, is based on a U.S. definition. The definitions below refer to certain U.S. requirements (i.e., state laws) that apply to Expatriate employees who are citizens and/or permanent residents of the U.S.; the general definitions apply to all Expatriate employees, including those who are not citizens or permanent residents of the U.S.

Your eligible dependents are:

- Your lawfully married spouse (regardless of gender), or common-law spouse if you live in a U.S. state that recognizes common-law marriages, or your civil union partner/domestic partner ("hereafter referred to as "partner"), if you live in a U.S. state that recognizes such partnerships. If you are legally separated, divorced or ended your partnership, your spouse/partner is *not* an eligible dependent unless mandated by state law; at any time you cannot cover more than one person as a spouse/ partner;
  - **Note:** Because civil union partnerships registered domestic partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships and registered domestic partnerships are not subject to the domestic partnership certification process, which is required if your partnership is not registered. However, under U.S. federal law, all partnerships are subject to the same tax treatment.
  - When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, certification of domestic partnership (satisfying the requirements set forth later in this document) or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways.
  - Your partner;
- Your partner's eligible dependents;

- Your children under the age of 26 (as of December 31 of the plan year that precedes the year in which the coverage applies) who are:
  - Your biological children;
  - Your legally adopted children (for purposes of coverage under the plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first);
  - Your stepchildren; and
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your disabled child beyond age 26 if he or she was covered under the plan before age 26 and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age.

You may also cover your disabled adult child age 26 or older who was disabled when you began employment with Citi and you enrolled him or her when you were first eligible to do so. You must have a letter from the U.S. Social Security Administration stating that your child is disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your benefits

Note: Your married child's spouse and children are not eligible for Citi coverage.

For Expatriates in locations where laws applicable to the U.S. Social Security Administration do not apply, it will be necessary for you to contact Aetna International to review your child's medical history so Aetna International can make a determination of benefits.

Dependent Verification Process

After you are auto enrolled, or when you add an eligible dependent to your coverage due to a change in status, you are required to submit proof of the dependent's eligibility for coverage (for example, a copy of your government-issued marriage license, children's birth certificate, passport, visa or rental agreement). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from your coverage.

You must also keep your dependent information current.

- When you are automatically enrolled during the Annual Enrollment period, you can change your dependent information.
- When you change your coverage category as a result of a qualified change in status, you must notify the Citi Benefits Center of any updates in dependent information.

Disabled Children

If your eligible dependent child is permanently and totally disabled as defined for purposes of obtaining U.S. Social Security benefits and (a) is covered under the Plans before reaching the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his or her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage, including, but not limited to, continuing to be permanently and totally disabled.

Enrolling in Group Universal Life (GUL) Insurance

USD-, HKD- and SGD-compensated Expatriates, as well as their spouses/partners, can enroll in, increase or reduce their GUL insurance coverage.

- **The enrollment process for GUL insurance:** You do not enroll in GUL through the Citi Benefits Center via ConnectOne. Instead, you enroll in GUL coverage by contacting MetLife. To enroll in GUL coverage for you and/or your spouse/partner, you must complete and submit an enrollment form directly to MetLife. You can download the form from the Expatriate Program Support page of *Citi For You* website or you can obtain an enrollment form by calling MetLife directly at +**1 (888) 830-7380**. The enrollment period to enroll in GUL coverage is 31 days from your initial transfer date, if you have not previously enrolled in the maximum GUL benefit permitted.
- **If your benefits eligible pay is reduced**, your GUL amount will continue to be based on the higher benefits eligible pay unless you call MetLife to request that the GUL amount be reduced. Once you reduce coverage, you can increase it only by purchasing additional multiples of your highest benefits eligible pay. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective. GUL coverage for an employee ends at age 95 if you continue to pay the premiums after your employment ends.
- **If you are enrolling for the first time as newly eligible** and you are enrolling (i) within your initial eligibility period of 31 days of your eligibility or (ii) for an amount no greater than three times your benefits eligible pay (not exceeding US($) 500,000 or US($) 1.5 million), or(iii) as a result of a qualified change in status, you will not be required to provide evidence of good health by completing an evidence of insurability questionnaire or undergoing a physical exam. Please note if you are enrolling otherwise, you will be required to provide evidence of insurance and the increased amount of coverage will be effective upon approval by MetLife up to the maximum allowable amount.
- **Increase your GUL insurance amount.** If your benefits eligible pay for the 2024 plan year increased to US($) 200,000 or more, you will not be eligible for company-paid Basic Life insurance. However, if you have not previously elected the maximum coverage under the GUL, during this special enrollment period you can elect GUL insurance equal to one times your benefits eligible pay, not to exceed US($) 500,000, without providing evidence of good health within 31 days after the loss of your Basic Life and Basic AD&D coverage. You can enroll or increase your GUL insurance by completing a GUL Enrollment/Change form, available on the Expatriate Program Support page of *Citi For You* website or by calling MetLife directly at +**1 (888) 830-7380**.
- **If you leave Citi, you may continue your GUL coverage.** However, MetLife will bill you directly at a higher rate than the Citi group rate. The rate will become effective the month following your termination of employment.

Enrolling in Supplemental Accidental Death and Dismemberment (AD&D) Insurance

- You may enroll in Supplemental AD&D coverage, provided by MetLife, from one to 10 times your benefits eligible pay (not to exceed US($) 500,000, up to a maximum coverage amount of US($) 5 million). If your benefits eligible pay is not an even multiple of US($) 1,000, your benefits eligible pay will be rounded up to the next US($) 1,000. Your cost is based on coverage you elect. If your benefits eligible pay is reduced, your Supplemental AD&D amount will continue to be based on the higher benefits eligible pay unless you call MetLife at +**1 (888) 830-7380** to request that the Supplemental AD&D amount be reduced.

- To enroll in Supplemental AD&D coverage for you and/or your spouse/partner, you must complete and submit an enrollment form directly to MetLife. You can download the form from the Expatriate Program Support page of *Citi For You* website or you can call MetLife directly to obtain an enrollment form at +**1 (888) 830-7380**.
- You may enroll you and/or your spouse/partner for Supplemental AD&D coverage at any time without providing evidence of insurability.
- You can enroll in Supplemental AD&D insurance coverage for your spouse/partner in increments of US($) 10,000 to a maximum of US($) 100,000. You do not need to buy Supplemental AD&D insurance for you to elect coverage for your spouse/partner.
- You may also enroll your eligible children in Supplemental AD&D coverage from US($) 5,000 to US($) 20,000, in US($) 5,000 increments at any time without evidence of insurability.
- If you leave Citi, you may continue your Supplemental AD&D coverage. MetLife will bill you at a higher rate than the Citi group rate effective the month following your termination. MetLife will send information to you on how to continue this coverage.
- If coverage ends, your spouse/partner can continue his/her Supplemental AD&D coverage on an individual basis. Call MetLife at +**1 (888) 830-7380**.

Enrolling in Long-Term Disability (LTD)

If your benefits eligible pay, for benefit purposes for the 2024 plan year increased above US($) 50,000.99 or if you are hired with benefits eligible pay above US($) 50,000.99, you will be automatically enrolled in LTD coverage. For purposes of calculating your LTD benefit, benefits eligible pay is limited to a maximum of US($) 500,000. In no event shall the monthly benefit exceed US($) 25,000 per month.

- You will have 90 days from your initial transfer date to decline coverage by notifying the Citi Benefits Center.
- If you decline coverage within the 90-day period, the premiums paid will be refunded to you.
- You can still decline coverage after the 90-day period. However, your premiums paid will not be refunded to you.

Please note: if you decline the LTD coverage and subsequently decide to enroll, you will be required to provide evidence of insurability to be considered for coverage unless your enrollment is the result of a qualified change in status. For certain qualified changes in status, such as a divorce or the death of a dependent, you can enroll in LTD coverage without having to provide evidence of good health.

How to Decline Coverage or Make Changes to Your Benefits

Call the Citi Benefits Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or, call the Citi Benefits Center through ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option. Citi Benefits Center representatives are available from 8 a.m. to 8 p.m. Eastern time, Monday through Friday.

How to Review Your Benefits Online

To review your benefits, visit the Your Benefits Resources™ (YBR™) website through My Total Compensation and Benefits at www.totalcomponline.com.

- **Expatriates** can log on using their User ID and Single Sign-on.

For Technical Issues if you need assistance accessing My Total Compensation and Benefits at www.totalcomponline.com, call +1(888)-630-7913 if you are calling within the U.S. For International callers please call +1(480)-712-4745.

Reminder

If web issues prevent you from accessing your information online, you can call the Citi Benefits Center.

Enrollment in the Citi health and insurance benefits is not mandatory; however, you will be automatically enrolled in the Citi Expatriate Medical and Dental Plans and LTD coverage when you are first hired as an Expatriate or transferred to an Expatriate assignment.

If you want **Aetna International Open Choice® PPO medical and/or dental and LTD coverage**, you do not need to take any action. However, for medical and dental coverage, to ensure that your claims are processed correctly, you should verify that you and your dependents' information is correctly displayed on the confirmation of enrollment sent to your permanent address on Citi's records. You can also view this information by visiting YBR™. Call the Citi Benefits Center via ConnectOne to make any corrections.

Once enrolled in medical and/or dental coverage, you will have the opportunity to change your elections (drop medical/dental or both) during the Annual Enrollment period for the following plan year. If you do not make any changes during the Annual Enrollment period, you will be assigned the same coverage the following plan year, beginning January 1.

You can choose to decline: (i) Citi Expatriate Medical Plan (ii) Dental Plan or (iii) LTD coverage, or all three within 90 days of your expatriate transfer date by calling the Citi Benefits Center via ConnectOne. If you decide to opt out of coverage within your initial 90-day auto enrollment period, you will receive a refund of your premiums paid. If you opt out of coverage, you will have the core coverage described earlier, along with any GUL and/or Supplemental AD&D coverage you elected. In addition, you can decline the LTD coverage after 90 days in which you were enrolled; however, you will not receive a premium refund.

After You Are Auto Enrolled

Confirmation Statement

A couple of weeks after you are auto enrolled; you will receive a confirmation of your enrollment from the Citi Benefits Center via email. You can also view your auto enrollment on-line by visiting the Your Benefit's Resources™ (YBR™) website, available through My Total Compensation and Benefits.

If you find an error, call the HR Shared Services (HRSS) North America Service Center immediately at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option.

Beneficiary Forms

If you are eligible for Basic Life insurance, you will need to designate a beneficiary.

You can designate or update your beneficiaries on YBR™ through My Total Compensation and Benefits at www.totalcomponline.com (Expatriates can log on using their User ID and Single Sign-on).

Once on YBR™, go to "Headings" above "Welcome" and then:

- Click on "Health and Insurance";
- Click on the "Beneficiaries" link under Overview Heading; and

- Select "Employee Basic Life/AD&D."
- If you enroll in GUL or Supplemental AD&D insurance, you must complete a Beneficiary Designation Form for Expatriates available on the Expatriate Program Support page of *Citi For You* website.

Updating Your Home Address

Important information — such as medical ID cards — will be mailed to your home address on file according to Citi's records.

To update your home address, visit the *Citi For You* website. From within the "Manage My Data section", click "View All" and enter the Username and Single Sign-On Password that you use for most other Citi applications. Update your address in the "My Addresses screen". Please keep in mind that the address entered will become your permanent mailing address.

Paying for Your Benefits

Citi pays for core benefits and contributes toward the cost of medical and dental coverage for you and your dependents. Your contribution for medical coverage will depend on the amount of your benefits eligible pay and your coverage category. Coverage categories are described on page 15. You can find the cost to enroll in all coverage categories on Your Benefit Resources™.

Benefits Paid with Pretax Dollars

Contributions for medical and dental coverage are deducted from your pay before hypothetical taxes are withheld. Your contributions for medical and dental coverage are based on your benefits eligible pay and the coverage category you select. Citi contributes more toward the cost of medical and dental coverage for lower-paid employees and less toward the cost for higher-paid employees.

Benefits Paid with After-Tax Dollars

Contributions for GUL insurance, Supplemental AD&D insurance and LTD are deducted from your pay after hypothetical taxes are withheld.

Benefits Eligible Pay and Your Benefits

Benefits eligible pay is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life insurance benefits;
- Basic AD&D insurance benefits;
- GUL insurance and costs;
- Supplemental AD&D insurance and costs; and
- Business Travel Accident/Medical insurance benefits.

If you are a new hire or if you were not benefits eligible before your Expatriate assignment, your benefits eligible pay at the time you are hired will be equal to your annual base salary. For future years, your benefits eligible pay will be based on the standard benefits eligible pay definition, described below.

2024 Definition of Benefits Eligible Pay

If you are enrolling during the Annual Enrollment period for coverage effective January 1, 2024, your benefits eligible pay for the purpose of benefits enrollment is made up of the following:

1. Annual base pay as of June 30, 2023;
2. Commissions paid from January 1-December 31 in the year prior to enrollment to capture an entire year of commissions paid; commissions paid from January 1-December 31, 2022 will be used for the 2024 Annual Enrollment calculations;
3. Cash bonuses (other than the cash portion of any annual discretionary incentive/retention award package) paid in the period January 1-December 31 in the year prior to enrollment; cash bonuses paid in the period January 1-December 31, 2022 excluding the cash portion of the annual discretionary incentive award/retention package dated January 2022 will be used for the 2024 Annual Enrollment calculations;
4. Annual discretionary incentive/retention award package dated in the year of enrollment; includes, as applicable, cash bonus, Capital Accumulation Program (CAP) Award and Deferred Cash Award. Annual discretionary incentive/retention award packages dated January/February 2023 will be used for the 2024 Annual Enrollment calculations.

If you became Expatriate staff on or after June 30, 2023, and you did not transfer from U.S. domestic staff, your benefits eligible pay for 2024 is your annualized base pay as of the date you became Expatriate staff.

If You Become Disabled

If you go out on a disability, your benefits eligible pay will be recalculated for annual enrollment after you return from the disability leave, if your leave extends beyond the benefits eligible pay calculation period for purposes of annual enrollment for the 2024 plan year or beyond. Your benefits eligible pay will not change while you are out on a disability leave.

Coverage Categories

Citi offers four coverage categories. Your coverage category will be based on your dependent information received. If you need to change your coverage category due to a change in family status, contact the Citi Benefits Center.

- **Employee only:** Coverage for you only;
- **Employee Plus Spouse/Partner:** Coverage for you and your spouse/partner only;
- **Employee Plus Child(ren):** Coverage for you and your eligible child(ren), including the eligible child(ren) of your spouse/partner; and
- **Employee Plus Family:** Coverage for you, your eligible spouse/partner, your eligible children and your spouse's/partner's eligible children.

You can change your coverage category during the Annual Enrollment period and within 31 days of a qualified change in status. The cost of coverage in each of the above coverage categories varies.

In addition, your cost for medical coverage will depend on your benefits eligible pay. You will find your costs for 2024 on YBR™.

Qualified Changes in Status

You must report to the Citi Benefits Center any qualified change of status that affects your benefits within 31 days of the event by following the process described under "How to report a qualified change in status event." Do not report qualified changes in status to Aetna International. Aetna International must receive any status changes from the Citi Benefits Center.

Depending on the event, and the benefits in which you are eligible to participate, you can enroll in or cancel your medical, dental, LTD and/or GUL.

Examples of qualified changes in status are:

- Marriage to a same or opposite sex spouse, entry into a civil union partnership, legal separation, divorce or termination of a partnership;
- Meeting the eligibility requirements to qualify as a partner (through registration or certification);
- The birth or adoption of a child;
- The loss of coverage eligibility for a dependent child who, for example, becomes ineligible due to age;
- The loss of coverage under your spouse's/partner's or other employer's plan;
- The death of a spouse/partner or dependent child;
- The issuance of a Qualified Medical Child Support Order (QMCSO);
- The start of a military leave of absence;
- Loss of group Basic Life insurance;
- The loss of Medicaid or Children's Health Insurance Program (CHIP) coverage; and
- The start of eligibility for state premium assistance.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Medical Plan, as long as you and your dependents are eligible but not already enrolled in the Medical Plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. The special enrollment also would permit you to enroll in the Medical Plan due to loss of Medicaid or CHIP coverage.

How to Report a Qualified Change in Status Event

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

To add a dependent, you must report the name, date of birth, and, if applicable, U.S. Social Security number for each dependent you want to add or remove from your coverage. If you are adding a newborn, you must report all information within 31 days (and report the U.S. Social Security number when you obtain it, if applicable).

Even if you are already enrolled in Citi family medical and dental coverage, you must report a new dependent. Otherwise, your new dependent's claims will not be paid. Report new dependents to the Citi Benefits Center by following the instructions below. **Do not contact Aetna International.** Aetna International must receive any status changes from the Citi Benefits Center.

When reporting a new dependent who you wish to enroll in Expatriate benefits, you may have to change your coverage category. For example, you are enrolled for "Employee Only" coverage and then you get married. To cover your new spouse, you must report information about your new spouse and change from the "Employee Only" to the "Employee Plus Spouse/Partner" coverage category. Additional contributions will be required.

To report a change in status, call the HR Shared Services (HRSS) North America Service Center at **1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call the Citi Benefits Center through ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option.

You can also report a change in status on YBR™ through My Total Compensation and Benefits at www.totalcomponline.com.

- Expatriates can log on using their User ID and Single Sign-on

Deadline to Report a Qualified Change in Status Event

You must report dependent information to the Citi Benefits Center within 31 days beginning with the day after the qualified change in status event. Otherwise, you will not be able to change your coverage or your dependent's coverage until the next Annual Enrollment period unless you have another qualified change in status.

Plan Changes You Can Make at Any Time

You can cancel, enroll in or change the following coverage at any time (if applicable).

Long-Term Disability (LTD): If your benefits eligible pay is less than or equal to US($) 50,000.99, LTD is a core benefit automatically provided at no cost to you. If your benefits eligible pay is US($) 50,001 or more, LTD is an optional benefit, in which you will be automatically enrolled, unless you were previously enrolled or elect to decline the automatically enrolled LTD coverage. If you decline such LTD coverage and subsequently decide to enroll, you will be required to provide evidence of insurability to be considered for coverage unless your enrollment is the result of a qualified change in status.

The LTD portion of the Disability Plan will not cover any total disability caused by, contributed to or resulting from a pre-existing condition until you have been enrolled in the Disability Plan for 12 consecutive months. A pre-existing condition is an injury, sickness or pregnancy for which — in the three months prior to the effective date of coverage — you received medical treatment, consultation, care or services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care or treatment.

Group Universal Life (GUL) insurance: You can enroll in GUL coverage which is administered by MetLife. MetLife does not require evidence of good health to enroll:

- When first eligible (as a new hire or newly eligible for Citi benefits as an Expatriate employee) if enrolling for up to three times the amount of your benefits eligible pay, not to exceed US($) 500,000, and the total is less than US($) 1.5 million;
- For one times your benefits eligible pay, not to exceed US($) 500,000, as a result of losing Basic Life insurance coverage due to benefits eligible pay of US($) 200,000 or above (as a new hire or an increase in benefits eligible pay) and certain other qualified changes in status.

However, MetLife will require evidence of good health:

- To enroll at any other time;
- To enroll for an amount greater than three times your benefits eligible pay, not to exceed US($) 500,000, or US($) 1.5 million; or
- To increase the amount of your current coverage.

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

Supplemental Accidental Death and Dismemberment (AD&D) insurance: You may enroll for Supplemental AD&D coverage at any time. Enrollment in this coverage does not require evidence of good health. You must be actively at work before coverage will be effective.

Partner Benefits

Citi offers benefits coverage to your partner.

You may cover your partner and his or her eligible child(ren) under the following plans:

- Medical;
- Dental;
- Group Universal Life (GUL);
- Supplemental Accidental Death and Dismemberment (AD&D) insurance; and
- Life insurance (for children).

You may enroll your partner and his or her eligible children in the medical and/or dental plan. You may enroll your partner in GUL and/or Supplemental AD&D insurance even if you do not enroll in the GUL and/or Supplemental AD&D plan.

Note: Citi's Expatriate Medical Plan does not have a pre-existing condition limitation or exclusion that would prevent you from enrolling your partner in the Medical Plan or from your partner receiving benefits for a specific condition or illness.

If both you and your partner are employed by Citi and are benefits-eligible, each of you can elect coverage individually or one of you can enroll and claim the other as a dependent. You cannot enroll as an individual and be claimed as your spouse's/partner's dependent

When You Can Enroll Your Partner in Citi Coverage

You can enroll your partner and his or her eligible children for Citi benefits during Annual Enrollment (for coverage effective January 1 of the following year) or within 31 days of a qualified change in status. Examples of qualifying changes in status that will allow you to enroll your partner and his or her eligible children are:

- Registration of your partnership from a jurisdiction or municipality that provides such documentation of partnerships;
- Certification of Partnership (requires completion of a form, available by calling the Citi Benefits Center);
- The birth or adoption of a child; or
- Your partner's loss of benefits coverage in another employer's plan.

You must speak with a Citi Benefits Center representative to request the Partner Coverage Forms. Call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

The cost of coverage for a partner is the same as the cost for a spouse. The cost of coverage for a partner's child(ren) is the same as the cost for a dependent child.

Who Is Eligible for Partner Benefits?

You are eligible to enroll your partner in Citi coverage if you are an Expatriate employee who is active. If you are an Expatriate employee who is on an approved leave of absence, you can enroll your partner in Citi Expatriate medical and dental coverage. However, if you are not actively at work, you cannot enroll your partner in GUL insurance or Supplemental AD&D.

As noted above, if your domestic partnership is registered in any state or under any local government authorized to provide such registration, your registration will be accepted as proof of your domestic partnership. If your domestic partnership is not registered, you will need to complete a form that certifies the following:

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

Evidence of Financial Interdependence/Dependence

Citi may require you to provide evidence of your financial interdependence (or partner's financial dependence) by providing two or more of the following forms of documentation:

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

Attestation/Completion of Forms

To cover a partner, you and your partner must first complete forms attesting to your partnership, if your partnership is not registered as noted above.

If you are a new hire, new transfer or newly eligible for Expatriate benefits and your partner is listed in the Expatriate payroll system as an eligible dependent, he or she will automatically be enrolled in the Citi Expatriate Medical and Dental plans. The Citi Benefits Center will email you a partnership attestation form to complete and send back to them. You will have 90 days from your initial transfer date to decline coverage.

Call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Eligibility for Your Partner's Children

The children of your partner are eligible for coverage if they satisfy the definition under the U.S. Internal Revenue Service (IRS) section 152(f)(1), which defines "child" as your child (whether natural born or adopted), stepchild or eligible foster child and:

- Are under the age of 26 as of December 31 of the plan year that precedes the enrollment year; or
- Were covered under the Plans before age 26 and become incapable of self-sustaining employment due to a disability, in which case they may be eligible for coverage beyond such age; or
- Were disabled adults when you began your employment with Citi and you enrolled them when you were first eligible to do so. You must have a letter from the U.S. Social Security Administration stating that your child is disabled. If you do not have such a letter, your Citi health plan will evaluate the child's condition before adding him or her to your benefits.

For Expatriates in locations where laws applicable to the U.S. Social Security Administration do not apply: Contact Aetna International to review your domestic partner's child's medical history so it can make a determination of benefits.

No dependent can be covered under these plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Cost of Partner Benefits

If your partner and his or her children:

- **Qualify as your dependents under U.S. tax law**, your contributions for partner medical and dental coverage will be deducted from your pay before taxes are withheld.
- **Do not qualify as dependents under U.S. tax law**, you will pay for their medical and dental coverage with after-tax dollars.

The cost of coverage for a partner is the same as it is for a spouse. The cost of coverage for a partner's child(ren) is the same as it is for a dependent child. You will find the cost to enroll in each coverage category on YBR™.

Hypothetical Tax Implications

Your hypothetical taxes may be affected when you enroll your partner in Expatriate benefits.

If Your Partner Does NOT Qualify as a Hypothetical Tax Dependent

If your partner and his or her child(ren) do not satisfy the definition of a hypothetical tax dependent, the full cost of any medical and/or dental coverage for your partner and/or his or her child(ren) is considered "imputed income." This amount will be shown on your pay statement and, if applicable, your Form W-2 for the year in which coverage was effective. You will pay hypothetical taxes on the amount of imputed income.

Example

Total Citi cost for employee-only coverage whose benefits eligible pay is US($) 200,001 is US($) 116.79 per month. Total Citi cost for employee + spouse/partner coverage is US($) 303.34.

The US($) 186.55 cost for partner coverage is considered imputed income, and you will pay hypothetical taxes on this amount.

If Your Partner Qualifies as a Hypothetical Tax Dependent

If your partner and his or her child(ren) qualify as hypothetical tax dependents, your contributions for their medical and/or dental coverage will be taken before hypothetical taxes are withheld and there are generally no additional tax costs to you.

A member of your household generally will qualify as your hypothetical tax dependent if:

- You provide more than 50% of his or her financial support;
- The individual receives less income than the U.S. Internal Revenue Service-allowed annual amount of gross income in any calendar year US($) 5,050 in 2024; and
- The individual lives with you for the entire year.

If You and Your Partner Marry

Report your qualified change in status to the Citi Benefits Center within 31 days after the date of marriage and request that the imputed income calculation and taxes be stopped. Otherwise, imputed income will continue to be considered in calculating hypothetical tax.

If You Terminate Your Partnership

If your partnership ends, you must complete and submit a Termination of Partnership Form to terminate partner coverage. You can obtain the required documents by calling the Citi Benefits Center. If your registered partnership is terminated pursuant to a legal proceeding, you can submit such documents ending your partnership. To add a new partner, you must wait six months from the date your termination attestation form is received, unless your new partnership is registered, as previously noted. Hypothetical taxes paid on the imputed income are not refundable.

Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Medical Coverage

You will be reimbursed at the same level when you receive care outside or in the U.S. from a provider in the Aetna International network. When seeking care in the U.S., you will pay more out of your pocket if you use a provider who does not participate in the Aetna International network (an out-of-network provider). The Aetna International network is available in the U.S. only.

Aetna International

Aetna International ID Cards

After you are auto enrolled in the Expatriate medical/dental benefit plans for the first time, you will receive an Aetna International ID card for you and, if applicable, your family members. Each ID card will be specific to the member with coverage. ID cards can also be printed online. After your enrollment, please allow four to six weeks to receive these cards in the mail.

The ID cards you receive after your initial enrollment will be valid as long as you are enrolled. ID cards are not reissued annually, they do not expire and they are valid globally.

About Aetna International

Aetna International specializes in Expatriate benefits. Aetna International's customer service representatives are available 24/7. AT&T's language line is available so you or your spouse/partner can use any language to speak with an Aetna International representative.

Aetna International Websites

Your secure Aetna International Member Website, also known as the Health Hub is available 24/7. With Aetna Health Hub, you can:

- Submit claims,
- Find care outside the U.S.,
- View/edit member details,
- View documents, and
- Elect recurring reimbursement election (RRE).

From the Aetna Health Hub, you will be automatically directed to the Aetna Navigator for various tasks such as:

- Viewing status of a claim/claim history,
- Finding care within the U.S., and
- Printing temporary ID cards.

To have access to these sites, you first must register on the Health Hub. To register:

- Go to www.aetnainternational.com.
- Click on the "Log In/ Register" button in the top right hand corner.
- Continue to "Log In / Register" in the drop down.
- Click "register" on the next screen.
- Enter the employee's first name, last name and date of birth, as prompted.
- Select "Aetna International Plan Member" under plan type.
- Enter your WID (which can be found on your ID card) under member ID.
- Accept terms & conditions.
- Click on "get started."
- Enter the employees email address. Proceed to create a username, password, and security question on the next screen.
- Click "continue."
- Select your destination country/city, preferred language and country of citizenship on the next screen.
- Click "register."

By registering for Aetna Health Hub, you will automatically be registered for the Aetna Navigator. Once logged in to either site, you can pass between the two sites without having to log in again

When to Use Aetna's Websites

- Use www.aetnainternational.com to find international providers, obtain health and security information for more than 200 countries and obtain translation guides for drug and medical terms in multiple languages.
- Use www.aetna.com to find U.S. providers, print ID cards, access personalized benefit information including electronic explanation-of-benefit notices and an itemized list of completed claims, and order prescription drug refills.

Choosing an Aetna International Provider

Inside the U.S.

You can obtain an Aetna provider directory by:

- Visiting Aetna's website at **www.aetna.com**; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

Physicians, hospitals and other health care providers contract with Aetna to provide services for a negotiated fee to members covered by Aetna health plans. You will commonly hear of physicians and hospitals referred to as either "in-network" or "out of network."

- "In-network" means that the physician or hospital is contracted with Aetna and will bill for negotiated rates established as part of the contract. Seeking care at an in-network provider usually means that you will pay less for the services you receive. You will also have lower out-of-pocket expenses when you use in-network providers in the U.S.
- "Out-of-network" means that the physician or hospital does not have a contract with Aetna and, therefore, is free to bill in accordance with its own fee schedule. Being able to seek care out of network may offer you more convenience when accessing care, but it could cost you more.

Outside the U.S.

When you are outside the U.S., this Plan acts as an "indemnity plan," meaning you can seek care from the provider of your choice. You will have to pay out of pocket for these services and then submit your claim to Aetna for reimbursement. For inpatient and some high-cost outpatient procedures outside the U.S., Aetna International may be able to arrange for payment directly to the facility so that you are only required to pay for your coinsurance at the time of service. Contact the Aetna International Service Center for more information.

You can obtain an Aetna provider directory by:

- Visiting Aetna's website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

Aetna International Partnership Countries

Aetna International has formed partnerships with local providers in the following three assignment countries:

- Brazil: Gama Saude
- Mexico: Sinergia Medica
- UAE: Allianz Orient

If you are assigned to any of these countries, you will receive:

- A welcome kit and member ID card from Aetna International to be used when you and your dependents incur medical expenses outside of your assignment country.
- A partnership company welcome kit and member ID when you seek care in your assignment country.

Additional information, such as a welcome letter, "What to Do When," and program guidelines for each of the partnership countries, can be found on the Expatriate Program Support page of the *Citi For You* website. Click on Expatriates, Benefits, then Aetna International.

Expatriate Medical and Prescription Drug Plan Coverage at-a-Glance

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Annual deductible • Individual • Maximum per family	None None	US($) 500 US($) 1,000
Annual medical out-of-pocket maximum (includes deductible, medical coinsurance and medical copayments) • Individual • Maximum per family	US($) 1,000 US($) 2,000	US($) 3,000 US($) 6,000
Hospital services		
• Hospital inpatient • Semiprivate room and board • Doctors' charges • Lab, Radiology and X-ray • Surgical care and anesthesia **Note:** In some countries, charges are based on room type	85% coverage	70% coverage after deductible
Outpatient • Surgical care • Lab and X-ray	85% coverage	70% coverage after deductible
Emergency room	85% coverage	85% coverage, 70% if not a true emergency after deductible
Physician services		
Physician office visit	85% coverage	70% coverage after deductible
Specialist office visit	85% coverage	70% coverage after deductible
Allergy treatment	85% coverage for first office visit, no deductible applies	70% coverage after deductible
Maternity • Physician office visit • Hospital delivery	100% for routine prenatal office visits; 85% coverage for non-routine office visits and hospital delivery	70% coverage after deductible

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Wellness/preventive care benefits		
Child preventive physical exams (Children ages 0-22) Seven exams first year of life, three exams second and third years of life, and one exam per year thereafter	100% coverage (subject to frequency limits)	100% coverage, no deductible applies
Adult preventive physical exams (Adults age 22-65) One exam every 12 months	100% coverage (subject to frequency limits)	100% coverage, no deductible applies
Adult and child Immunizations	100% coverage	100% coverage, no deductible applies
Routine care (subject to frequency limits)		
Routine gynecological exams Includes one exam and Pap smear per calendar year	100% coverage	100% coverage, no deductible applies
Mammograms Includes one baseline exam for age 35-39 and one annual exam for ages 40+	100% coverage	100% coverage, no deductible applies
Prostate Specific Antigen (PSA) Includes one PSA per calendar year for males 50+	100% coverage	100% coverage, no deductible applies
Routine vision exam Includes dilation; limited to one exam every 12 months	100% coverage, up to a maximum of U.S. ($) 70 per calendar year	85% coverage, up to a maximum of US($) 70 per calendar year; no deductible applies
Eyeglasses Includes one pair of frames plus lenses **Contact lenses** • Conventional • Disposal • Medically necessary	Up to US($) 200 reimbursement for frames, lenses and contact lenses every 12 months	Up to US($) 200 reimbursement for frames, lenses and contact lenses every 12 months
Routine hearing exam (Includes 1 routine exam every 24 months)	85% coverage	70% coverage after deductible
Hearing aids • *Adults:* Every 36 months (per ear) • *Children:* Every 24 months (per ear) • US($) 1,200 maximum	85% coverage	70% coverage after deductible
Mental health services		
Mental health inpatient coverage No limits	85% coverage	70% coverage after deductible
Mental health outpatient coverage No limits	85% coverage	70% coverage after deductible
Alcohol/drug abuse services		
Substance abuse inpatient coverage No limits	85% coverage	70% coverage after deductible
Substance abuse outpatient coverage No limits	85% coverage	70% coverage after deductible
Other professional care		
Physical/occupational therapy (all therapies combined)[1] Limited to 60 visits a year for in-network and out-of-network combined; you may be eligible for additional visits with Plan approval after a medical necessity review.	85% coverage	70% coverage after deductible
Speech therapy[1] Limited to 90 visits a year for in-network and out-of-network combined; you may be eligible for additional visits with Plan approval after a medical necessity review.	85% coverage	70% coverage after deductible

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Spinal manipulation therapy[1] Limited to 20 visits per calendar year for in-network and out-of-network combined	85% coverage	70% coverage after deductible
Acupuncture Must be administered by a medical doctor or a licensed acupuncturist	85% coverage	70% coverage after deductible
Applied behavioral analysis therapy	85% coverage	70% coverage after deductible
Skilled nursing facility 120 days per calendar year	85% coverage	70% coverage after deductible
Infertility medical procedures US($) 24,000 lifetime medical maximum; contact Aetna International for specifics	85% coverage	70% coverage after deductible up to lifetime maximum
Infertility prescription drugs US($) 7,500 out-of-network lifetime pharmacy maximum; contact Aetna International for specifics	85% coverage	70% coverage after deductible up to lifetime maximum
Durable medical equipment	85% coverage	70% coverage after deductible
Prescription drug coverage		
Prescription drugs[2]	85% coverage; includes mail-order drugs obtained in the U.S. only;	70% coverage after deductible;

1. Visit limit is not applicable when there is a diagnosis of mental health, behavioral health or substance abuse, including Autism Spectrum Disorder.

2 Herbal medicine covered when prescribed by a licensed practitioner in countries where the herbal medicine meets standard of care guidelines.

Wellness Services

Charges for routine care exams are based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams including well-woman and well-child exams and immunizations.

Preventive care services are included in this plan. Both exams and immunizations are covered by in-network providers in the U.S. and out-of-network providers outside the U.S. at 100% with no deductible to meet.

Preventive care services include but are not limited to:

- Routine physical exams and diagnostic tests, for example, complete blood count (CBC), cholesterol blood test and urinalysis and immunizations;
- Well-child services and routine pediatric care and immunizations for children; and
- Routine well-woman exams.

In addition to well-woman exams, the following women's preventive services are covered by in-network providers at 100% with no deductible to meet:

- Well-woman office visit to obtain recommended preventive services that are developmentally appropriate, including preconception and prenatal care;
- Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures and patient education and counseling for women with reproductive capacity (excluding drugs that induce abortion);

- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period (including costs for renting breast pumps and nursing-related supplies);
- Human papillomavirus virus (HPV) DNA testing as part of cervical cancer screenings for women age 30 and older; and
- Screening for gestational diabetes.

Additional preventive care services covered in full by Citi medical plans, as part of the Affordable Care Act (also referred to as PPACA) include:

- Preventive services related to pregnancy for dependent children;
- Anesthesia performed in connection with a preventive colonoscopy;
- Genetic counseling and BRCA genetic testing for women who have had non BRCA-related breast or ovarian cancer;
- Human immune-deficiency virus (HIV) counseling and screening for all sexually active people;
- Interpersonal and domestic violence screening and counseling;
- Counseling on sexually transmitted infections for all sexually active people;
- Tobacco-use cessation (for non-pregnant adults): counseling, behavioral interventions and US Food and Drug Administration (FDA)-approved pharmacotherapy;
- Tobacco-use cessation (for pregnant women): counseling and behavioral interventions;
- Diabetes screening (at-risk adults): screening for abnormal blood glucose as part of cardiovascular risk assessment for overweight or obese adults ages 40–70 years; and intensive behavioral counseling about diet and exercise for patients with abnormal blood glucose;
- High blood pressure screening (adults): hypertension screening for adults ages 18 and older;
- Obesity Preventive Counseling; and
- Alcohol/Drug Abuse Preventive Counseling.

Contact your plan for details.

vHealth Virtual Care

Your Citi Expatriate Medical plan includes vHealth (Worldwide) -- a virtual health service that brings doctors to you without the need to visit an office. With vHealth, you have access to doctors 24 hours a day via video or telephone.

Some highlights of vHealth include:

- vHealth is free
- You can use it as often as you need
- Signing up is quick and easy

Health is completely confidential and doctors are specially trained to conduct remote consultations and provide the guidance and support you need, whether it's a diagnosis, help managing a chronic condition or getting a prescription.

Register today!

Be sure to register, so you have access when you need it:

- Visit vhealth-teladochealth.com or download 'vHealth (Worldwide)' from Google Play or the App Store
- Follow the registration instructions to open an account
- Use access code Aetna267 during registration

If you have any problems accessing the service, please contact the vHealth support team:

- Email: vHealth@teledochealth.com
- Tel UK: +44 (0) 20 3499 2851
- Tel USA: +1 (0) 8572 563 784

Be sure to save 'vHealth (Worldwide)' contact information in your phone to book appointments quickly in the future. Please note: as prescription regulation varies country to country, vHealth cannot guarantee prescriptions.

Virtual Care within the United States

vHealth is available only to plan members outside of the United States. Only those members with current addresses outside the US will be invited to register. If a registered member travels to the US, they will not be able to consult with a vHealth doctor during their stay. However, while in the US, covered plan members can access virtual care through Teladoc. With Teladoc, you can talk with a doctor within an hour by phone or app from wherever you are inside the United States. For more information visit , visit www.teladoc.com or call 1 (855) TELADOC (835-2362).

Gender Affirmation Benefits

For gender affirmation treatment benefits for members with gender dysphoria, the criteria that are used for determining the medical necessity of services for the diagnosis and treatment are based on the 7th edition of the clinical guidelines set forth by the World Professional Association for Transgender Health (WPATH) in their Standards of Care document. However, not all of the services included in WPATH are covered. Please see below for those services that are generally covered and those services that are not covered.

Many of the services noted below require pre-service authorization. Contact the Plan's Member Services for details.

It is strongly recommended that you call the applicable claims administrator before receiving any related services to ensure that the services you seek are covered under the Plan.

Generally, covered expenses include:

- Outpatient office visits
- Hormone therapy (and any subsequent associated risks) is covered under the pharmacy benefit (refer to the Prescription Drugs section for coverage information and any pre-service authorization instructions)
- Puberty suppression
- Voice modification and communication therapy
- Genital surgery and surgery to change secondary sex characteristics (including but not limited to thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) when the treatment plan conforms to the most recent edition of the World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Inpatient hospital services or treatment require pre-service authorization

- Reconstructive and complementary procedures (including but not limited to tracheal shave, male chest reconstruction, pectoral implants, gluteal augmentation, hair removal and hair transplants) according to the most recent edition of the World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. The Plan will review appropriateness of treatment. Inpatient hospital services or treatment require pre-service authorization.
- All preventive care is covered regardless of sex assigned at birth.

Note that all covered expenses are subject to plan pre-authorization limits and WPATH eligibility criteria.

Not covered

- Services performed solely for beautification or to improve appearance;
- Charges for services or supplies that are not based on the guidelines set forth by the WPATH.
- Donor sperm and eggs

If a member has followed all of the criteria and clinical guidelines outlined in the WPATH Standards of Care, the plan will not cover costs related to reversal procedures or services. However, complications of procedures derived from reversal surgeries or treatments that are medically necessary will be covered.

Maternity Benefits

Group health plans and health insurance issuers generally may not, under U.S. federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, U.S. federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under U.S. federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay that does not exceed 48 hours/96 hours. The above does not apply to births that take place outside the U.S.; contact the Aetna International Service Center for more information.

Reminders about Coverage for Newborns

To cover a newborn under your Citi medical/dental coverage, you must notify Citi within 31 days of the child's birth. See "How to report a qualified change in status event." While you may want to call Aetna International directly to report the birth of a child, your child will not be covered unless you call the Citi Benefits Center within 31 days. Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

You also can visit YBR™ through My Total Compensation and Benefits at **www.totalcomponline.com.**

Expatriates can log on using their User ID and Single Sign-on.

Covered Expenses and Exclusions

Covered expenses are defined as medical and related costs incurred by participants that qualify for reimbursement under the terms of the plan or insurance contract. The following is a list of covered services and exclusions.

Note that the expenses listed are examples of expenses covered and not covered. Call Aetna International toll free at **+1 (800) 231-7729** or **+1 (813) 775-0190** (collect calls accepted) for information about additional services or supplies and whether they are covered.

Abortion

Covered services include the following services provided by your **physician**:

- Abortion, including abortion drugs dispensed by a provider (including a telemedicine provider), where permitted by state and local laws.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first hospital to provide emergency services
- From one hospital to another if the first hospital can't provide the emergency services you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include pre-certified transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; limited to 100 miles
- When during a covered inpatient **stay** at a **hospital**, **skilled nursing facility** or acute rehabilitation **hospital**, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient treatment

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis is a process of applying interventions that:

- Systematically change behavior
- Are responsible for observable improvements in behavior

Behavioral health

Mental health treatment

Covered services include the treatment of mental health disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including: – Office visits to a **physician** or **behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **mental health disorders**
  - Other outpatient mental health treatment such as: o Partial hospitalization treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
  - You are homebound
  - Your physician orders them
  - The services take the place of a stay in a hospital or a residential treatment facility, or you are unable to receive the same services outside your home
  - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Substance related disorders treatment

Covered services include the treatment of substance related disorders provided by a hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital**, **psychiatric hospital**, or **residential treatment facility**.

- Outpatient treatment received while not confined as an inpatient in a **hospital**, **psychiatric hospital**, or **residential treatment facility**, including:
  - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
  - Individual, group, and family therapies for the treatment of **substance related disorders**
  - Other outpatient **substance related disorders** treatment such as:
    - Partial hospitalization treatment provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Intensive outpatient program provided in a facility or program for treatment of **substance related disorders** provided under the direction of a **physician**
    - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
      - You are homebound
      - Your **physician** orders them
      - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
      - The skilled behavioral health care is appropriate for the active treatment of a condition, illness, or disease
    - Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
    - Observation
    - Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. Peer support must be supervised by a **behavioral health provider**.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as defined in the federal Public Health Service Act, Section 2709.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising **experimental or investigational** interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an "approved clinical trial" only when you have cancer or a **terminal illness**. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- Aetna International determine you may benefit from the treatment

An approved clinical trial is one that meets all of these requirements:

- The Food and Drug Administration (FDA) has approved the drug, device, treatment, or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status, when this is required
- The clinical trial has been approved by an institutional review board that will oversee it
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization and:
  - It conforms to standards of the NCI or other applicable federal organization
  - It takes place at an NCI-designated cancer center or at more than one institution
- You are treated in accordance with the procedures of that study

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But, there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
- Repairing DME due to normal wear and tear
- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table

- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room. You can get **emergency services** from **network** or **out-of-network providers**.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized and
- Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** if you need more care

If both of the above conditions are met and you continue to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. Please refer to the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your **network physician** or **primary care physician** (**PCP**).

Non-emergency services

If you go to an emergency room for what is not an **emergency medical condition**, the plan may not cover your expenses. See the schedule of benefits for more information.

Gender affirming treatment

Covered services include certain services and supplies for gender affirming treatment.

Important note:

Visit https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the toll-free number on your ID card.

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn or improve your skills and functioning for daily living (e.g. therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational or speech therapist

- Hospital, skilled nursing facility or hospice facility
- Home health care agency
- Physician

Outpatient physical, occupational, and speech therapies

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (Speech function is the ability to express thoughts, speak words and form sentences)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Hearing aids

Hearing aid means:

- Any wearable, non-disposable instrument or device designed to aid or make up for impaired hearing
- Parts, attachments, or accessories

Covered services include prescribed hearing aids and the following hearing aid services:

- Audiometric hearing visit and evaluation for a hearing aid prescription performed by:
  - A physician certified as an otolaryngologist or otologist
  - An audiologist who:
    - Is legally qualified in audiology
    - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
    - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist
- Electronic hearing aids, installed in accordance with a **prescription** written during a covered hearing exam
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen or broken
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound
- Your **physician** orders them

The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home

- The services are a part of a home health care plan
- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker
- Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation

Hospice care

Covered services include inpatient and outpatient hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- Room and board
- Services and supplies furnished to you on an inpatient or outpatient basis
- Services by a hospice care agency or hospice care provided in a hospital
- Psychological and dietary counseling
- Pain management and symptom control

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
  - Physical and occupational therapy
  - Medical supplies
  - Outpatient **prescription drugs**
  - Psychological counseling
  - Dietary counseling

The following are not **covered services**:

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling including estate planning and the drafting of a will
- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
  - Sitter or companion services for you or other family members
  - Transportation
  - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood derivatives, but not the expense of the donated blood or blood product

The following are not **covered services**:

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a provider:

- To diagnose and evaluate the underlying medical cause of **infertility**.

- To do **surgery** to treat the underlying medical cause of **infertility**. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.

Comprehensive infertility services
Covered services include the following infertility services provided by an infertility specialist:

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- Artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

Infertility covered services may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, a "cycle" is defined as:

- An attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination
- An artificial insemination cycle with or without medication to stimulate the ovaries

You are eligible for these **covered services** if:

- You or your partner have been diagnosed with **infertility**
- You have met the requirement for the number of months trying to conceive through egg and sperm contact
- Your unmedicated day 3 Follicle Stimulating Hormone (FSH) level and testing of ovarian responsiveness meet the criteria outlined in Aetna's i**nfertility** clinical policy

Aetna's National Infertility Unit
Aetna's National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and **infertility** coordinators. They can help you with determining eligibility for benefits and **precertification**. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Infertility services exclusions:
The following are not **covered services**:

- All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to:
  - Imaging, laboratory services, and professional services
  - In vitro fertilization (IVF)
  - Zygote intrafallopian transfer (ZIFT)
  - Gamete intrafallopian transfer (GIFT)
  - Cryopreserved embryo transfers
  - Gestational carrier cycles
  - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.

- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Advanced reproductive technology (ART)

Advanced reproductive technology**,** also called "assisted reproductive technology", is a more advanced type of **infertility** treatment.

Covered services include the following services provided by an ART **specialist**:

- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan. For plans with cycle limits, an ART "cycle" is defined as:

One complete fresh IVF cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
One fresh IVF cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
Fertilization of egg and transfer of embryo	One half cycle
One cryopreserved (frozen) embryo transfer	One half cycle
One complete GIFT cycle	One full cycle
One complete ZIFT cycle	One full cycle

You are eligible for ART services if:

- You have met the comprehensive **infertility** eligibility requirements
- You have exhausted comprehensive **infertility** services benefits or have a clinical need to move on to ART procedures

The National Infertility Unit (NIU) can help you with determining eligibility for benefits and **precertification**. They can also give you information about our **infertility** Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your **infertility** services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned services that are proven to result in **infertility** such as: - Chemotherapy or radiation therapy that is established in medical literature to result in **infertility**
  - Other gonadotoxic therapies
  - Removing the uterus
  - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna's **infertility** clinical policy

Premature ovarian insufficiency
If your **infertility** has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Infertility services exclusions:
The following are not **covered services**:

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.

- Obtaining sperm from a person not covered under this plan.
- **Infertility** treatment when a successful pregnancy could have been obtained through less costly treatment.
- **Infertility** treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- **Infertility** treatment when **infertility** is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's **infertility** clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.
- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
- No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
- A shorter **stay**, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier

If the mother is discharged earlier, the plan will pay for 1 home visits after delivery by a health care **provider**. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out: - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth.
  - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:

Some surgeries can be done safely in a **physician's** office. For those surgeries, your plan will pay only for **physician** services and not for a separate fee for facilities.

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- A separate facility charge for **surgery** performed in a **physician's** office
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead.

Telemedicine may have a different cost share from other **physician** services. See your schedule of benefits.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. Aetna excludes **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not

covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. Contact Aetna for additional information.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Other covered services

Abortion drugs
Covered services include **prescription** drugs used for elective termination of pregnancy.

Contraceptives (birth control)
To prevent pregnancy, **covered services for females** include certain drugs and devices that the FDA has approved for that purpose. You will need a **prescription** from your **provider** and must fill it at a network pharmacy. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies
Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

- Blood glucose meters and insulin pumps

See the Diabetic services, supplies, equipment, and self-care programs section for medical **covered services**.

Immunizations
Covered services include preventive immunizations as required by the ACA when given by a network pharmacy. You can find a participating network pharmacy by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Risk reducing breast cancer prescription drugs
Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs
Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement.

For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Prescription drug exclusions:
The following are not **covered services**:

- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as a **covered service**
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a **covered service**

  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the booklet
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the booklet
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of **prescription** drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- **Prescription** drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which is illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper and drugs obtained for use by anyone other than the member as identified on the ID card
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- The Plan reserves the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**

  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or Aetna. This information is also available at https://www.healthcare.gov/.

Important note:

Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Breast-feeding support and counseling services
Covered services include assistance and training in breast-feeding and counseling services during pregnancy or after delivery. Your plan will cover this counseling only when you get it from a certified breast-feeding support **provider**.

Breast pump, accessories and supplies
Covered services include renting or buying equipment you need to pump and store breast milk.

Coverage for the purchase of breast pump equipment is limited to one item of equipment, for the same or similar purpose, and the accessories and supplies needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Counseling services
Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
  - Preventive counseling and risk factor reduction intervention
  - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet

  - Preventive counseling and risk factor reduction intervention
  - Nutritional counseling
  - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
  - Preventive counseling to help stop using tobacco products
  - Treatment visits
  - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Counseling services provided by a **physician** or other **provider** on contraceptive methods. These will be covered when you get them in either a group or individual setting.
- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
- Voluntary sterilization including charges billed separately by the **provider** for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.

The following are not preventive **covered services**:

- Services provided as a result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods, sterilization procedures or devices

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Prenatal care

Covered services include your routine pregnancy physical exams at the **physician**, **PCP**, OB, GYN or OB/GYN office. The exams include initial and subsequent visits for:

- Anemia screening
- Blood pressure
- Chlamydia infection screening
- Fetal heart rate check
- Fundal height
- Gestational diabetes screening

- Gonorrhea screening
- Hepatitis B screening
- Maternal weight
- Rh incompatibility screening

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, removal of polyps during a screening procedure, and a pathology exam on any removed polyp
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT)
- Lung cancer screenings
- Mammograms
- Prostate specific antigen (PSA) tests
- Sigmoidoscopies

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
- Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
- Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
  - Screening and counseling services on topics such as:
    - Interpersonal and domestic violence
    - Sexually transmitted diseases
    - Human immune deficiency virus (HIV) infections
  - High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician**, **PCP**, OB, GYN or OB/GYN for services including Pap smears
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Instruction and other services (such as attachment or insertion) so you can properly use the device
- Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
- Replacements required by ordinary wear and tear or damage

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
  - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
  - Treatment of physical complications of all stages of the mastectomy, including lymphedema
  - Prostheses

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a gross anatomical defect present at birth. The **surgery** will be covered if:
  - The defect results in severe facial disfigurement or major functional impairment of a body part
  - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in severe facial disfigurement or major functional impairment of a body part, and your **surgery** will improve function.

Covered services also include the procedures or **surgery** to sound natural teeth injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury.
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident.

These dental related services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
- The first placement of dentures or bridgework to replace lost teeth
- Orthodontic therapy to pre-position teeth

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital**, **skilled nursing facility** or **physician's** office, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital**, **skilled nursing facility**, or **physician's** office, is used to treat reversible pulmonary disease states, and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services are services needed to restore or develop your skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- Hospital, skilled nursing facility, or hospice facility
- Home health care agency
- Physician

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy
Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
  - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
  - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
  - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
  - Improve delays in speech function development caused by a gross anatomical defect present at birth (Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.)
- Cognitive rehabilitation associated with physical rehabilitation, but only when:
  - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
  - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include precertified inpatient skilled nursing facility care. This includes:

- Room and board, up to the semi-private room rate
- Services and supplies provided during a stay in a skilled nursing facility

Specialty prescription drugs

Covered services include specialty prescription drugs when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
  - A freestanding outpatient facility
  - The outpatient department of a **hospital**
  - A **physician** in the office
  - A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription** drug benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription** drug benefit.

Telemedicine

Covered services include telemedicine consultations when provided by a physician, specialist, behavioral health provider or other telemedicine provider acting within the scope of their license.

Covered services for telemedicine consultations are available from a number of different kinds of providers under your plan. Log in to your member website at https://www.aetna.com/ to review our telemedicine provider listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks
- Electronic vital signs monitoring or exchanges (e.g. Tele-ICU, Tele-stroke)

Tests, images and labs - outpatient

Diagnostic complex imaging services
Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds $500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a physician, hospital or other provider.

GCIT covered services include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- Human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Facilities/provider for gene-based, cellular and other innovative therapies

We designate facilities to provide GCIT services or procedures. GCIT **physicians**, **hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:

You must get GCIT **covered services** from the GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact Aetna so they can help you determine if there are other facilities that may meet your needs. If you do not get your GCIT services at the facility/**provider** Aetna designates, they will not be **covered services**.

The following are not **covered services** unless you receive prior written approval from the plan:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**

- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Infusion therapy
Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

Covered services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting Aetna.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug benefit. You can access the list of **specialty prescription drugs** by contacting Aetna.

Radiation therapy
Covered services include the following radiology services provided by a **health professional**:

- Accelerated particles
- Gamma ray
- Mesons
- Neutrons
- Radioactive isotopes
- Radiological services
- Radium

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Covered services also include:

- Travel and lodging expenses - If you are working with an IOE facility that is 100 or more miles away from where you live, travel and lodging expenses are **covered services** for you and a companion, to travel between home and the IOE facility

- Coach class air fare, train or bus travel are examples of **covered services**

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket** and limits, unless stated differently in this booklet and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment**, **payment percentage**, **deductible**, **maximum out-of-pocket**, and limits, unless stated differently in this booklet and schedule of benefits

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

Many pre and post transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

If you need care for an urgent condition, you should first seek care through your **physician**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses

- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include, but are not limited to, health care services provided through a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
- Preventive care immunizations administered within the scope of the clinic's license
- Individual screening and counseling services that will help you:
  - With obesity or healthy diet
  - To stop using tobacco products

General Exclusions

Gene-based, cellular and other innovative therapies (GCIT)
The following are not **covered services** unless you receive prior written approval from Aetna:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**.
- All associated services when GCIT services are not covered. Examples include:
  - Infusion
  - Lab
  - Radiology
  - Anesthesia
  - Nursing services

Jaw joint disorder treatment
Surgical and non-surgical medical, dental, diagnostic or therapeutic services related to **jaw joint disorder**

Missed appointments
Any cost resulting from a canceled or missed appointment

Nutritional support
Any food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- **Prescription** vitamins
- Medical foods
- Other nutritional items

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan

Other primary payer
Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Prescription or non-prescription drugs and medicines – outpatient

- Outpatient **prescription** or non-**prescription** drugs and medicines
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

Routine exams and preventive services and supplies

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services not permitted by law

Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

Services provided by a spouse, civil union partner, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member.

How the Plan Works

Deductible

For out-of-network coverage in the U.S., a deductible applies. The deductible is the amount of covered expenses that must be paid by you before the plan pays any benefit. Once you meet your annual deductible, the Plan will pay a percentage of maximum allowed amounts (MAA), subject to plan limits, for your remaining covered expenses in that plan year. After you meet your annual deductible, the Plan will pay 100% of covered charges.

There are two types of deductibles: Individual and family.

Individual	The amount each person must pay before benefits will be paid. **Note:** If the family deductible has been met, the individual deductible does not apply to the individual.
Family	The amount the family as a whole must pay before benefits will be paid.

A deductible does not apply to coverage outside of the U.S. The benefit level outside the U.S. will be the same as for "in-network coverage" in the U.S.

Out-of-Pocket Maximums for Medical and Prescription Drug Coverage

The medical out-of-pocket maximum limits the amount you will pay in a plan year if you or your family incurs large medical bills. The medical out-of-pocket maximum is the maximum amount of covered medical expenses you would have to pay out of your own pocket before most plan benefits will be payable at 100% of maximum allowed amounts (MAA).

Once the maximum out-of-pocket amount has been met, the .Plan will pay 100% of the MAA for covered medical costs for the remainder of the year. However, if the expenses incurred are higher than the MAA, the individual receiving the service is responsible for paying the difference between the MAA and the provider's charges even if the out-of-pocket maximum has been reached.

There are two types of out-of-pocket maximums: Individual and family.

Individual	The amount each member must pay at the coinsurance rate before most of his/her benefits are paid at 100%. **Note:** If the family out-of-pocket maximum has been met, the individual out-of-pocket does not apply to the individual.
Family	The amount all covered members as a whole will pay at the coinsurance rate before most benefits are paid at 100%.

Medical Necessity

To be covered by the Citi Expatriate Medical Plan, a service or supply must be considered medically necessary. A service or supply qualifies as *medically necessary* if it is a generally accepted health care practice and is required to treat your condition, as determined by Aetna International. This means it is deemed to be:

- Widely accepted among health care professionals as effective, appropriate and essential;
- Based on the recognized standards of the health care specialty involved;
- Not provided solely for personal comfort or convenience;
- The most cost-effective level of care that can be safely and adequately provided (for example, medically necessary inpatient care includes services that could not safely and adequately be provided through outpatient services);
- Provided, prescribed or approved by a legally licensed doctor of medicine practicing within the scope of his or her license; and
- Provided while you are covered under the Plan.

Aetna International, Citi's claims administrator for the Citi Expatriate Medical Plan, determines medical necessity.

Maximum Allowed Amount (MAA)

The MAA is any charge that, for services rendered by or on behalf of an out-of-network physician, does not exceed the amount determined by Aetna International in accordance with the applicable fee schedule.

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

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

Referrals to Medical Providers

Aetna International representatives can refer you and your covered family members to medical professionals in most countries. Additionally, local quality monitoring and case management will be available to help you and your covered family members manage an illness.

If you are assigned to work in the U.S. or you have covered treatment in the U.S., Citi encourages you to use an in-network provider in the Aetna network. If you do, you will have fewer out-of-pocket expenses for your medical care than if you use an out-of-network provider.

You do not need to select any doctor in advance. You can visit any doctor within the Aetna network to get the higher level of reimbursement.

You can find an extensive directory of both international and U.S. doctors in the Aetna International network by:

- Visiting Aetna International website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

If you are assigned to work outside the U.S. please refer to the "Choosing an Aetna in-network provider outside the U.S."

Prescription Drugs

The Citi Expatriate Medical Plan includes coverage for prescription medicines. Additionally, when you and your eligible family members are in the U.S. or its territories, you may access the Aetna Pharmacy Management network of more than 59,000 participating pharmacies to save money on prescriptions from doctors, dentists or hospitals/clinics.

You can use the Aetna International online directory to search U.S. destinations to find a participating pharmacy. Simply present your Aetna International ID card and prescription to the in-network pharmacist and he or she will collect your copayment and bill Aetna International for the balance due. If you fill your prescription at a non-participating pharmacy in the U.S., you must pay the entire cost and submit a claim for reimbursement under the non-preferred benefits of the plan.

Remember, the advantage of the Aetna Pharmacy Management program applies to those using participating pharmacies in the U.S. or its territories only. As an Aetna International member under the Citi Expatriate Medical Plan, you may go to any pharmacy anywhere in the world. However, you will need to pay for your prescription drug and then submit a claim form to Aetna International for medications obtained from non-participating pharmacies, which includes pharmacies outside the U.S.

Aetna Rx Home Delivery is Aetna's mail-order prescription drug service that ships maintenance medications to U.S. addresses only. U.S. federal law does not permit the mailing of prescription drugs outside the U.S. If you are a U.S. resident, you can receive prescriptions through the mail when you are on a home visit or temporarily residing in the U.S. U.S. residents are also eligible to fill three-, six-, nine- and 12-month prescriptions (based on your doctor's orders) at pharmacies throughout the U.S. that participate in Aetna's network.

For specialty and/or emergency medications unavailable in your country of assignment, please contact the CARE Team via Aetna International Member Services and ask to speak to a CARE Team nurse.

The CARE Team can also assist you with:

- Pre-trip planning specific to your assignment country;
- Coordinating routine and urgent medical care worldwide during your assignment;
- Locating providers and disease management specialists and in obtaining medical devices or prescription medications; and
- Coordinating and supervising medical evacuations and other emergency assistance.

Direct Settlement

As an Aetna International member, you are free to go to any hospital you choose, but some hospitals require payment at the time of service. For potentially high-cost procedures, it is most convenient to establish a direct-pay relationship with the hospital. This can be done online, or in an emergency, you or the provider can call the number on the back of your ID card at any time, day or night. Aetna International representatives are available 24/7 and they can assist in establishing a direct-pay arrangement.

When you access care at an Aetna International-contracted, direct-pay medical facility or provider, your out-of-pocket expenses may be reduced because, generally, you will be responsible for a smaller portion of the bill and Aetna International will pay the facility directly for any remaining covered expenses according to your specific benefits coverage.

If you do not find the facility that you are looking for in Aetna International's direct-pay database, you can request that Aetna International coordinate a one-time direct payment arrangement with that facility. If Aetna International is able to arrange for payment, it will evaluate the opportunity to add that facility to its list of regular direct-pay providers.

Claiming Expenses

You must file a claim to be reimbursed for your medical and dental expenses. In the U.S., medical providers in the Aetna International network often will file the claim for you. You can obtain claim forms:

- By copying the forms you receive from Aetna International after you enroll;
- By printing the forms from the Expatriate Program Support page of the *Citi For You* website;
- By printing the forms from the Aetna International website at www.aetnainternational.com; and
- By calling Aetna International to request a form; see the telephone number at the back of this book.

For medical and dental expenses incurred out of network in the U.S. and outside the U.S. you will be required to pay for the expense and submit a claim form to Aetna International for reimbursement. Aetna International accepts claims in any language without translation or currency conversion. When charges for expenses are converted to U.S. dollars, Aetna International will use the exchange rate on the date the expense was incurred.

Be Sure to File Claims Promptly!

The Citi Expatriate Medical Plan and Expatriate Dental Plan will not pay claims filed more than 12 months after the charges were incurred, unless the charges relate to a claim already on file.

Payment of Claims

When paying claims, Aetna International can:

- Electronically deposit your reimbursements for the cost of medical and dental care into your U.S. bank account; or
- Reimburse you, or pay the provider directly, in local currency.

You can indicate your preference for method of claims reimbursement on the claim form. Claims submitted are usually processed within 16 business days after receipt of the completed claim form.

Tips to Speed Claim Processing

- Be sure to fill out the claim form completely; an incomplete form may delay processing.
- Provide a diagnosis or explanation of treatment on the claim form.
- Be certain that all receipts are legible. Receipts must be fully itemized bills and/or detailed receipts that include diagnosis (nature of illness) and the procedures or services performed.
- Write your member identification number on each document submitted with your claim form (this number is located on your Aetna ID card).
- Be sure to indicate the name of the person who received care (either yourself or your dependent).
- Include contact information (phone, fax or email) where you can be reached in case Aetna International has any questions about your claim.
- State how and where you want the reimbursement issued.
- Fax or send an email with your form instead of mailing it.
- Save copies of your bills, receipts and claim forms.

You can submit your claim in any of four ways:

Mail	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543USA
Overnight delivery	Aetna International 4630 Woodland Corporate Blvd. Tampa, FL 33614 USA
Fax	For faster turnaround of claim payment, fax your claim form and supporting documentation to: Direct: **+1 (813) 775-0625** Toll free: **+1 (800) 475-8751**
Email	AiService@aetna.com
Member Portal	The fastest way for members to be reimbursed without having to fill out a paper claim form is through the member portal at **www.aetnainternational.com**.

Aetna International can reimburse your covered medical and dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT) or wire the money directly to your bank account. Aetna International will cover any applicable fees.

To select your method of reimbursement and preferred currency, complete the "Summary of Reimbursement" and, as applicable, "Banking" section(s) of the claim form. The choice of reimbursement is up to you.

Alternatively, if you prefer to be reimbursed the same way each time, you can advise Aetna International in one of the following ways:

By mail	Complete a Recurring Reimbursement Request form available at www.aetnainternational.com and either send it with your next claim or on its own.
Online	Visit the Aetna International member website at www.aetnainternational.com. • Click on the "Resources" tab at the top of the page. • Click "Forms." • Select "Online RRE Enrollment" under "Recurring Reimbursement Election (RRE)." • Complete the online form and send to Aetna International.

For more information about the currencies and payment methods in which Aetna International can provide claim reimbursement, visit www.aetnainternational.com or call the Aetna International Service Center using the telephone number on your member ID card or at the back of this book.

Claims and Appeals

When a claim comes in, you will receive a decision on how you and the Plan will split the expense. Aetna International will also explain what you can do if you disagree with a claims decision.

Claims are processed in the order in which they are received.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Claim Procedures

For claims involving out-of-network providers:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the Aetna International Service Center. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.
Proof of loss (claim)	• A completed claim form and any additional information required by the Plan.	• No later than 90 days after you have incurred expenses for covered benefits. • Aetna International won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send them notice and proof as soon as reasonably possible. • Proof of loss may not be given later than two years after the time proof is otherwise required, except if you are legally unable to notify Aetna International.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by Aetna International, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of Claims and Communicating Claim Decisions

You or your provider are required to send Aetna International a claim in writing. Aetna International will review that claim for payment to the provider.

There are different types of claims. The amount of time allowed to tell you about a decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent Care Claim

An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-Service Claim

A pre-service claim is a claim that involves services you have not yet received and which the Plan will pay for only if Aetna International pre-certifies them.

Post-Service Claim

A post service claim is a claim that involves health care services you have already received.

Concurrent Care Claim Extension

A concurrent care claim extension occurs when you ask Aetna International to approve more services than they already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent Care Claim Reduction or Termination

A concurrent care claim reduction or termination occurs when Aetna International decides to reduce or stop payment for an already approved course of treatment. The Plan will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from Aetna International or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If Aetna International upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time the Claims Administrator has to tell you about the decision.

Aetna International may need to tell your physician about their decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.

Type of notice	Urgent care claim	Pre-service Claim	Post-service claim	Concurrent care claim
Initial determination (Aetna International)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (Aetna International)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*Aetna International has to receive the request at least 24 hours before the previously approved health care services end.

Adverse Benefit Determinations

The Plan may pay many claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes the Plan will pay only some of the claim. And sometimes they may deny payment entirely. Any time the Plan denies even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if Aetna International rescinds your coverage entirely.

If the Plan makes an adverse benefit determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write to Aetna International Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna International will review the information and provide you with a written response within 30 calendar days of receiving the complaint. They will let you know if more information is needed to make a decision.

An Appeal

You can ask Aetna International to re-review an adverse benefit determination. This is called an appeal. You can make an appeal verbally or in writing.

Appeals of Adverse Benefit Determinations

You can appeal an adverse benefit determination. Aetna International will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Aetna International Member Services at the address on the notice of adverse benefit determination. Or you can call Aetna International Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like to be considered

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell the Plan if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling Aetna International that you are allowing someone to appeal for you. You can get this form by contacting Aetna International Member Services. You can use an authorized representative at any level of appeal.

You can appeal two times under this Plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent Care or Pre-Service Claim Appeals

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you (without having you fill out an authorized representative form).

Aetna International will provide you with any new or additional information that was used or that was developed to review your claim. Aetna International will provide this information at no cost to you before giving you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before the Plan tells you what their final decision is.

Timeframes for Deciding Appeals

The amount of time that the Plan has to tell you about decisions on an appeal claim depends on the type of claim as outlined below.

Type of notice	Urgent care claim	Pre-service Claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (Aetna International)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of Appeals Process

In most situations you must complete the two levels of appeal with Aetna International before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- Aetna International did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and Aetna International.

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:

- Your claim decision involved medical judgment.
- Aetna decided the service or supply is not medically necessary or not appropriate.
- Aetna decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If the claim decision is one for which you can seek external review, Aetna will say that in the notice of adverse benefit determination or final adverse benefit determination they send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To Aetna
- Within 120 calendar days (four months) of the date you received the decision
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. Aetna International will pay for information they send to the ERO plus the cost of the review.

Aetna will:

- Contact the ERO that will conduct the review of your claim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that you sent.
- Follow contractual documents and your plan of benefits.
- Send notification of the decision within 45 calendar days of the date your request form is received and all the necessary information.

Aetna International will stand by the decision that the ERO makes, unless they can show conflict of interest, bias or fraud. They will tell you of the ERO decision not more than 45 calendar days after receipt of your Notice of External Review Form with all the information you need to send in. But sometimes you can get a faster external review decision. Your provider must call or send Aetna International a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your provider states that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations

Your provider tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

Aetna International will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

Aetna International does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Dental Coverage

The Citi Expatriate Dental Plan was designed to encourage preventive care and to help pay the cost when you need dental treatment. You can visit any dentist anywhere in the world and receive coverage as described in this section.

The Plan pays benefits up to maximum allowed amounts. Coverage limits apply.

You can enroll in the Citi Expatriate Dental Plan coverage even if you do not enroll in the Citi Expatriate Medical Plan. You can enroll in coverage for you and/or your eligible dependents in one of the same four coverage categories available for medical coverage.

Aetna Dental PPO Network

If you or a covered dependent needs dental care in the U.S., you can take advantage of the Aetna Dental PPO Network.

You are not required to select an Aetna Dental Network provider. However, if you choose to go to an Aetna Dental Network provider you can take advantage of discounts available in most states.

You can also find a directory of dentists in the Aetna Dental Network by:

- Visiting the Aetna International website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the telephone numbers at the back of this book.

If you are assigned to work outside the U.S. you can choose to visit any dentist you wish.

Expatriate Dental Plan Coverage at-a-Glance

Annual individual deductible	US($) 75 per calendar year
Annual family deductible	US($) 225 per calendar year
Maximum annual benefit (per person)	US($) 2,000 per calendar year
Diagnostic and preventive services • Routine oral exams • Routine cleanings • Fluoride treatments • Sealants • X-rays	100% coverage; not subject to deductible • Up to two exams per calendar year • Up to two cleanings per calendar year • One fluoride application per calendar year, up to age 16 • Sealants up to age 19; age 14 and under (permanent molars only) • One full-mouth series X-ray per 36 months and up to two bitewing X-rays per year
Basic restorative • Fillings; amalgam (“silver”) and composite (“white”) • Extractions • Endodontic treatment • Oral surgery • Repair or re-cementing of crowns, inlays, onlays, bridgework or dentures • Periodontal treatment • General anesthesia (when medically necessary) • Emergency exams • Specialist’s exams • Palliative treatment (emergency only) and related X-rays	80% coverage after deductible
Major restorative • Inlays, onlays, crowns and gold fillings • Removable dentures • Fixed bridgework • Implants	50% coverage after deductible
Orthodontia services • Orthodontic X-rays • Retainers • Braces (coverage for employees and dependents)	50% coverage after deductible
Orthodontic lifetime maximum (per person)	US($) 2,000

Deductible

For all covered dental services, except diagnostic and preventive services, each covered person will pay an initial amount each calendar year, called the *deductible,* before the Plan will pay benefits. Once you meet your annual deductible, the plan will pay a percentage of maximum allowed amounts, subject to plan limits, for your remaining covered expenses in that year.

Charges applied to the deductible in the last quarter of the year will carry over and be applied to the following year’s deductible.

If you enroll for dependent coverage, the Plan will limit the combined amount you and your covered dependents must pay in deductibles each calendar year. The limit is three times the individual deductible amount. Your family will not have to pay more in deductibles for the year than the family limit, whether you or any dependent reaches the individual deductible.

Alternative Treatment

Often there is more than one acceptable way to treat a particular dental condition. For example, a partial denture may be a professionally acceptable alternative to a fixed bridge.

When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the Plan will cover.

By obtaining an advance claim review as described below, you can determine in advance if Aetna International will pay benefits based on an alternative method of treatment.

Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the Plan will pay for proposed services. Knowing ahead of time which services are covered by the Plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

Important Note: The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may request supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the Plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups. In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result.

Dental Services Covered under the Citi Expatriate Medical Plan

The Citi Expatriate Medical Plan covers certain treatment of the mouth, teeth, jaw, jaw joints or supporting tissues, including certain major dental work, surgery or orthodontic treatment needed after an accidental injury affecting sound, healthy teeth. Call Aetna International, at the telephone number at the back of this book, if you have questions about whether a service is covered under the Medical Plan or the Dental Plan.

Dental Rules and Limitations

Several rules apply to the dental benefits. Following these rules will help you use your Pan to your advantage by avoiding expenses that are not covered by your plan.

- Orthodontic treatment rule

  - Orthodontic treatment is covered on the date active orthodontic treatment begins.
  - This benefit does not cover charges for the following:
    - Replacement of broken appliances
    - Re-treatment of orthodontic cases
    - Changes in treatment necessitated by an accident
    - Maxillofacial surgery
    - Myofunctional therapy
    - Treatment of cleft palate
    - Treatment of micrognathia
    - Treatment of macroglossia
    - Lingually placed direct bonded appliances and arch wires (i.e. “invisible braces”)

- Orthodontic limitation for late enrollees
  - The Plan will not cover the charges for an orthodontic procedure for which an active appliance for that procedure has been installed within the 2 year period starting with the date you became covered by the Plan. This limit applies only if you do not become enrolled in the plan within 31 days after you first become eligible.
- Reimbursement policies: We have the right to apply Aetna reimbursement policies. Those policies may reduce the negotiated charge or recognized charge. These policies consider factors such as:
  - The duration and complexity of a service
  - When multiple procedures are billed at the same time, whether additional overhead is required
  - Whether an assistant surgeon is necessary for the service
  - If follow up care is included
  - Whether other characteristics modify or make a particular service unique
  - When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
  - The educational level, licensure or length of training of the provider
- Aetna reimbursement policies are based on our review of:
  - The Centers for Medicare and Medicaid Services’ (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
  - Generally accepted standards of dental practice and
  - The views of providers and dentists practicing in the relevant clinical areas
  - We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Replacement rule: Some **eligible dental services** are subject to your Plan’s replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays

- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services
- These **eligible dental services** are covered only when you give us proof that:
  - While you were covered by the Plan: You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
  - The present item cannot be made serviceable, and is:
    - A crown installed at least 5 years before its replacement.
    - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.
  - While you were covered by the Plan:
    - You had a tooth (or teeth) extracted.
    - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
    - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Dental Expenses Not Covered

The Citi Expatriate Dental Plan does not cover certain dental expenses. If you have any question about whether a service that is not listed here is covered, call Aetna International. Here are examples of expenses that are *not* covered: Call Aetna International, at the telephone number at the back of this book, if you have questions about whether a service is covered under the Medical or the Dental Plans

- These dental exclusions are in addition to the exclusions that apply to health coverage.
- Any instruction for diet, plaque control and oral hygiene.
- A crown, bridge or gold restoration for which the tooth was prepared before the patient was covered;
- Charges in connection with a work-related injury or illness covered by any Workers' Compensation or any similar law;
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed as covered;
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect;
- Services considered to be unnecessary or experimental in nature;

- Services provided or paid by or through a governmental agency or authority, political subdivision or public program; and
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided under the Plan. Facings on molar crowns and pontics will always be considered cosmetic.
- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.
- Court-ordered services and supplies: Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.
- Dental services and supplies
  - Acupuncture, acupressure and acupuncture therapy
  - Asynchronous dental treatment
  - Crown, inlays and onlays, and veneers unless for one of the following:
    - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
    - The tooth is an abutment to a covered partial denture or fixed bridge
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
  - Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
  - First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
  - General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
  - Instruction for diet, tobacco counseling and oral hygiene
  - Mail order and at-home kits for orthodontic treatment
  - **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
  - Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
  - Services and supplies provided in connection with treatment or care that is not covered under the Plan
  - Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
  - Replacement of teeth beyond the normal complement of 32
  - Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
  - Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
  - Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons

- Temporomandibular joint dysfunction/disorder
- Dental services and supplies that are covered in whole or in part:
  - Under any other part of this Plan
  - Under any other Plan of group benefits provided by Citi
- Any dental examinations needed:
  - Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
  - Because a court order requires it.
  - To buy insurance or to get or keep a license.
  - To travel.
  - To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Claiming Expenses

You must file a claim to be reimbursed for your medical and dental expenses. In the U.S., medical providers in the Aetna International network often will file the claim for you. You can obtain claim forms:

- By copying the forms you receive from Aetna International after you enroll;
- By printing the forms from the Expatriate Program Support page of the *Citi For You* website;
- By printing the forms from the Aetna International website at www.aetnainternational.com; and
- By calling Aetna International to request a form; see the telephone number at the back of this book.

For medical and dental expenses incurred out of network in the U.S. and outside the U.S. you will be required to pay for the expense and submit a claim form to Aetna International for reimbursement. Aetna International accepts claims in any language without translation or currency conversion. When charges for expenses are converted to U.S. dollars, Aetna International will use the exchange rate on the date the expense was incurred.

Be Sure to File Claims Promptly!

The Citi Expatriate Medical Plan and Expatriate Dental Plan will not pay claims filed more than 12 months after the charges were incurred, unless the charges relate to a claim already on file.

Payment of Claims

When paying claims, Aetna International can:

- Electronically deposit your reimbursements for the cost of medical and dental care into your U.S. bank account; or
- Reimburse you, or pay the provider directly, in local currency.

You can indicate your preference for method of claims reimbursement on the claim form. Claims submitted are usually processed within 16 business days after receipt of the completed claim form.

Tips to Speed Claim Processing

- Be sure to fill out the claim form completely; an incomplete form may delay processing.

- Provide a diagnosis or explanation of treatment on the claim form.
- Be certain that all receipts are legible. Receipts must be fully itemized bills and/or detailed receipts that include diagnosis (nature of illness) and the procedures or services performed.
- Write your member identification number on each document submitted with your claim form (this number is located on your Aetna ID card).
- Be sure to indicate the name of the person who received care (either you or your dependent).
- Include contact information (phone, fax or email) where you can be reached in case Aetna International has any questions about your claim.
- State how and where you want the reimbursement issued.
- Fax or send an email with your form instead of mailing it.
- Save copies of your bills, receipts and claim forms.

You can submit your claim in any of four ways:

Mail	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543USA
Overnight delivery	Aetna International 4630 Woodland Corporate Blvd. Tampa, FL 33614 USA
Fax	For faster turnaround of claim payment, fax your claim form and supporting documentation to: Direct: **+1 (813) 775-0625** Toll free: **+1 (800) 475-8751**
Email	AiService@aetna.com

Aetna International can reimburse your covered medical and dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT) or wire the money directly to your bank account. Aetna International will cover any applicable fees.

To select your method of reimbursement and preferred currency, complete the "Summary of Reimbursement" and, as applicable, "Banking" section(s) of the claim form. The choice of reimbursement is up to you.

Alternatively, if you prefer to be reimbursed the same way each time, you can advise Aetna International in one of the following ways:

By mail	Complete a Recurring Reimbursement Request form available at www.aetnainternational.com and either send it with your next claim or on its own.
Online	Visit the Aetna International member website at www.aetnainternational.com. • Click on the "Resources" tab at the top of the page. • Click "Forms." • Select "Online RRE Enrollment" under "Recurring Reimbursement Election (RRE)." • Complete the online form and send to Aetna International.

For more information about the currencies and payment methods in which Aetna International can provide claim reimbursement, visit www.aetnainternational.com or call the Aetna International Service Center using the telephone number on your member ID card or at the back of this book.

Claims and Appeals

When a claim comes in, you will receive a decision on how you and the Plan will split the expense. Aetna International will also explain what you can do if you disagree with a claims decision.

Claims are processed in the order in which they are received.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Claim Procedures

You or your dental provider are required to send Aetna International a claim in writing. They will review that claim for payment to the provider or to you as appropriate. The following table explains the claims procedure:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the Aetna International Service Center. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send Aetna International notice and proof within 90 days • If you are unable to complete a claim form, you may send: • A description of services • Bill of charges • Any dental documentation you received from your dental provider
Proof of loss (claim) **When you have received a service from an eligible dental provider, you will be charged.** **The information you receive for that service is your proof of loss.**	• A completed claim form and any additional information required by the Plan.	• You must send notice and proof within 90 days
Benefit payment	Written proof must be provided for all benefits. If any portion of a claim is contested by Aetna International, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	Benefits will be paid as soon as the necessary proof to support the claim is received.

Communicating Claim Decisions

The amount of time allowed to tell you about a decision on a claim is shown below.

Post-Service Claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial determination (Aetna International)	30 days
Extensions	15 days
Additional information request (Aetna International)	30 days
Response to additional information request (you)	45 days

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If Aetna International upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Adverse Benefit Determinations

The Plan may pay many claims at the full rate negotiated charge with in-network providers and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes the Plan will pay only some of the claim. And sometimes they may deny payment entirely. Any time the Plan denies even part of the claim that is an "adverse benefit determination" or "adverse decision."

If the Plan makes an adverse benefit determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write to Aetna International Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna International will review the information and provide you with a written response within 30 calendar days of receiving the complaint. They will let you know if more information is needed to make a decision.

An Appeal

You can ask Aetna International to re-review an adverse benefit determination. This is called an appeal. You can make an appeal verbally or in writing.

Appeals of Adverse Benefit Determinations

You can appeal an adverse benefit determination. Aetna International will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Aetna International Member Services at the address on the notice of adverse benefit determination. Or you can call Aetna International Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like to be considered

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell the Plan if you choose to have someone else appeal for you (even if it is your dental

provider). You should fill out an authorized representative form telling Aetna International that you are allowing someone to appeal for you. You can get this form by contacting Aetna International Member Services. You can use an authorized representative at any level of appeal.

You can appeal two times under this Plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for Deciding Appeals

The amount of time that the Plan has to tell you about decisions on an appeal claim depends on the type of claim as outlined below.

Type of notice	Post-service claim
Appeal determinations at each level (Aetna International)	30 days
Extensions	None

Exhaustion of AppealsProcess

In most situations you must complete the appeal process with Aetna International before you can pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

Aetna International will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

Aetna International does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Disability

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

Definition of Years of Service for the STD and LTD Benefits

For purposes of the Citigroup Disability Plan, your years of service are based on your actual time providing services to Citi as an employee.

Short-Term Disability (STD)

The Short-Term Disability (STD) coverage is a core benefit available to eligible Expatriates. No enrollment is necessary. However, you must report all disabilities to the Plan administrator, and your claim must be approved before you can receive a benefit. To report a disability, call the HR Shared Services (HRSS) North America Service Center at
+1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam), and press 1 when prompted, or call Connect One **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "disability or FMLA-related absences" option. You can also call MetLife, Citi's disability claims administrator, directly at **+1 (888) 830-7380**.

STD pays 100% of your base salary (not benefits eligible pay) during an approved disability of up to 13 weeks.

When STD Benefits Are Payable

STD benefits are payable if you incur a total disability while an "Active Employee."

You are an "Active Employee" if you:

- are an Eligible Employee working for Citi doing all the material duties of your occupation at (i) your usual place of business; or (ii) some other location that your Citi requires you to be; and
- are not a temporary or seasonal employee.

You will be deemed an Active Employee if:

- you meet the above conditions; and
- you are absent from work solely due to vacation days, holidays, scheduled days off, or approved leaves of absence not due to Disability.

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

To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You are not considered to have a disability if your illness, injury or pregnancy prevents you from commuting to and from work only. If you are able to perform the essential duties of your job at home or elsewhere and are unable to commute to work, this limitation does not constitute a disability for benefits purposes. You cannot qualify for an STD benefit if you return to work on a part-time basis (except for statutory benefits required under applicable state law).

If you qualify for STD benefits, return to work, and then — within a 30-day period or less — you are unable to return to work for the same or related total disability, your absence will be processed as a recurrent claim. You will be eligible to receive an STD benefit for the balance of your STD period of up to 13 weeks (for a reduced period to reflect the STD benefits paid prior to your absence) and may qualify for a Long-Term Disability (LTD) benefit.

If either a recurrent disability or an unrelated disability occurs after you returned to work for more than 30 days following an initial disability, you may be eligible for additional STD benefits, not to exceed 13 weeks, if approved.

STD benefits may be offset by any monies owed to Citi and/or by any state benefits, including Workers' Compensation and Social Security disability benefits. However, the plan does not subrogate STD payments.

No STD benefit is payable for claims submitted more than six months after the date of disability. However, you can request that benefits be paid for late claims if you can show that:

- It was not reasonably possible to give written proof of disability during the six-month period; and
- Proof of disability satisfactory to the claims administrator was given as soon as reasonably possible.

Exclusions

You will not receive STD benefits for any of the following:

- A disability when your care is not supervised by a qualified physician;
- Injuries caused by war, international armed conflict, riot or civil disobedience;
- Intentional self-inflicted injury;
- A disability that begins during an unapproved leave of absence;
- A disability that results from an attempted or committed felony, assault, battery, other public offense or during incarceration; or
- A disability resulting from cosmetic surgery, which is a surgical procedure that is not necessary to correct a sickness or injury (except for statutory benefits required under applicable state law).

Long-Term Disability (LTD)

LTD benefits are provided through a MetLife group disability policy in the event you suffer a covered disability. You may be eligible to receive LTD benefits if your approved STD claim was paid for 13 weeks. LTD coverage is offered to replace 60% of your benefits eligible pay (predisability earnings) determined on the day before your approved STD. Your "predisability earnings" under the MetLife group disability policy constitutes your benefits eligible pay for purposes of the LTD benefit.

For purposes of calculating your LTD benefit, benefits eligible pay is limited to a maximum of US($) 500,000. In no event shall the monthly benefit exceed US($) 25,000 per month.

Disability benefits received from any state disability plan, Social Security and the LTD portion of the Plan, combined, will not exceed 60% of your benefits eligible pay.

Participation

If your benefits eligible pay is less than or equal to US($) 50,000.99, LTD is a core benefit provided at no cost to you. If your benefits eligible pay is US($) 50,001 or more, LTD is an optional benefit, in which you will be automatically enrolled, unless you were previously enrolled or elect to decline LTD coverage..

The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year (following Annual Enrollment) unless you decline coverage. Visit YBR™ during Annual Enrollment for the cost.

Option to Decline LTD coverage

If you were not enrolled in LTD coverage prior to your expatriate transfer date and you do not elect "no coverage" during enrollment related to your expatriate transfer date, you will be automatically enrolled in LTD coverage. If you are automatically enrolled, you may decline the LTD coverage within 90 days from your initial transfer date and receive a refund of premiums paid. You may also decline LTD coverage after the initial 90-day coverage period, and your premiums paid will not be refunded. To decline coverage, call the Citi Benefits Center.

Note that if you decline LTD coverage or decide to opt out of such coverage and want to enroll at a later date, you will need to provide evidence of good health and possibly undergo a physical exam before LTD coverage can be approved (unless you have a qualified change in status).

If you have been enrolled in LTD coverage for one year and leave Citi, for a reason other than retirement, you may be able to convert your Citi LTD coverage under the group policy to an individual policy within 31 days after your termination date. The maximum benefit of this individual policy is US($) 3,000 per month. You can obtain a conversion form by calling the Citi Benefits Center. Call +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

LTD Coverage at a Glance

If Your Benefits Eligible Pay Is:	
US($) 50,000.99 or less	• Citi provides LTD coverage at *no* cost to you. • Your benefit is subject to hypothetical tax.
From US($) 50,001 to US($) 500,000	• You will pay for coverage with after-tax dollars. • Your benefit is not subject to hypothetical tax.

You may be eligible to receive LTD benefits after 13 continuous weeks of an approved STD. Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins as shown in the table below).

Age When Total Disability Begins	Date Monthly LTD Benefits Will Stop
Under age 60	Upon attaining age 65
Age 60	The date the 60th monthly benefit is payable
Age 61	The date the 48th monthly benefit is payable
Age 62	The date the 42nd monthly benefit is payable
Age 63	The date the 36th monthly benefit is payable
Age 64	The date the 30th monthly benefit is payable
Age 65	The date the 24th monthly benefit is payable
Age 66	The date the 21st monthly benefit is payable
Age 67	The date the 18th monthly benefit is payable
Age 68	The date the 15th monthly benefit is payable
Age 69 or over	The date the 12th monthly benefit is payable

Unless you have other LTD coverage, you should consider enrolling or maintaining the coverage in which you were automatically enrolled, as applicable, under the LTD portion of the Citigroup Disability Plan. LTD coverage protects you in the event your ability to work is impaired by an accident or sickness.

In addition, the LTD benefit portion of the Citigroup Disability Plan will not cover any total disability caused by, contributed to or resulting from a pre-existing condition until you have been enrolled in the plan for 12 consecutive months.

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

When LTD Benefits Are Payable

If you are enrolled in LTD coverage (pursuant to the terms of the Disability Plan on your date of hire) and have been disabled for 13 weeks of STD, you may be eligible for an LTD benefit.

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

If you have consecutive, concurrent or continuous disabilities, related or unrelated, which continue for a period of more than 13 weeks you will receive an LTD benefit from MetLife, if eligible and approved. If you are approved for Social Security Disability Insurance (SSDI) for yourself and/or your dependents, your monthly LTD benefit will be offset by SSDI, dependent SSDI, and any state disability benefits you may receive. The state and Social Security benefits may be subject to tax.

Your LTD benefit will not be offset for any SSDI cost-of-living adjustments. If you are approved for SSDI retroactively and receive a lump-sum SSDI award, you are required to submit any overpayment of benefits to MetLife. Any other income you receive while you are receiving LTD benefits may be used to offset your LTD benefit as described in the LTD contract between MetLife and Citi. This is not applicable to Individual Disability Insurance Plans (IDIs).

While on an LTD leave, MetLife will send you instructions on how to apply for SSDI benefits, tax information, benefits continuation information and relevant forms.

Claims and Appeals Information

Procedures for Presenting Claims for Benefits

All claim forms needed to file for disability benefits can be obtained from the Citi Benefits Center who will also be ready to answer questions about the disability benefits and to assist you or, if applicable, the claimant in filing

claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be returned to the Citi Benefits Center who will certify that you are insured under the LTD portion of the Citigroup Disability Plan and will then forward the claim form to Metropolitan.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Citi Benefits Center who is usually able to provide the necessary information.

Requesting a Review of Claims

In the event a claim has been denied in whole or in part, you or, if applicable, the claimant can request a review of your claim by Metropolitan. This request for review should be sent to Group Insurance Claims Review at the address of Metropolitan's office which processed the claim within 60 days after you or, if applicable, the claimant received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, the claimant believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, the claimant deems appropriate.

Metropolitan will re-evaluate all the information and you or, if applicable, the claimant will be informed of the decision in a timely manner.

Life and Accident Insurance

Basic Life Insurance

Citi provides Company-paid Basic Life insurance through MetLife at no cost to you if your benefits eligible pay is less than US($) 200,000. If your annual benefits eligible pay is equal to or greater than US($) 200,000, you are not eligible for company-paid Basic Life insurance.

The benefit is equal to your benefits eligible pay rounded up to the nearest US($) 1,000, to a maximum of US($) 200,000. Benefits eligible pay is recalculated each June 30, and the new amount is effective each following January 1.

An Important Note about Taxable Income

Since Citi pays the full cost of your Basic Life insurance up to a maximum of US($) 200,000, hypothetical taxes may be payable on the value of coverage over US($) 50,000, as required by U.S. law. The value of life insurance coverage over US($) 50,000 will be included in taxable income. This amount, called "imputed income," is reported as taxable income on your pay statement throughout the year and on your Internal Revenue Service (IRS) Form W-2, Wage and Tax Statement (if applicable). Imputed income is based on the amount of Basic Life insurance coverage above US($) 50,000.

If your benefits eligible pay is more than US($) 50,000, you may elect to have only US($) 50,000 in Basic Life insurance. You will not be subject to imputed income and the related tax, but you will also forego the additional benefit. You will not have the opportunity to enroll in Basic Life equal to your benefits eligible pay or to reduce coverage until the next Annual Enrollment period.

If Your Benefits Eligible Pay Increases to US($) 200,000 or Above

Once your benefits eligible pay is equal to or exceeds US($) 200,000 and you are ineligible for Basic Life and Basic AD&D, you may have the opportunity to enroll or increase your Group Universal Life (GUL) insurance coverage equal to one times your benefits eligible pay up to US($) 500,000 *without* providing evidence of good health, subject to the Plan's maximum coverage limits.

If you are enrolled in GUL up to the maximum coverage amount — the lesser of 10 times your benefits eligible pay or US($) 5 million — you are not eligible to increase GUL insurance coverage.

Basic Life Accelerated Benefits Option (ABO)

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

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

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

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

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

Naming a Beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or change your beneficiary for Basic Life insurance at any time by visiting YBR™. If there is no beneficiary designated or no surviving beneficiary at your death, the Claims Administrator will determine the beneficiary in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If a beneficiary or payee is a minor or incompetent to receive payment, the Claims Administrator will pay his or her guardian.

Basic Accidental Death and Dismemberment (AD&D) Insurance

Citi provides Basic AD&D insurance through MetLife at no cost to you if your benefits eligible pay is less than US($) 200,000. Basic AD&D pays a benefit if you are dismembered or die because of an accidental injury. If your annual benefits eligible pay is equal to or above US($) 200,000, you are *not* eligible for Company-paid Basic AD&D insurance.

The benefit is equal to your benefits eligible pay, rounded up to the nearest US($) 1,000, to a maximum of US($) 200,000. Benefits eligible pay is recalculated each June 30, and the new coverage amount is effective the following January 1.

Naming a Beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or change your beneficiary for Basic AD&D insurance at any time by visiting YBR™. If there is no beneficiary designated or no surviving beneficiary at your death, the Claims Administrator will determine the beneficiary in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If a beneficiary or payee is a minor or incompetent to receive payment, the Claims Administrator will pay his or her guardian.

Continuing Basic Life and Basic AD&D on an Individual Basis

You can convert your Basic Life coverage to an individual policy if your benefits eligible pay reaches the threshold that makes you ineligible for coverage or after the termination of employment from Citi. You will receive a Health and Welfare Benefits Conversion/Portability Notice from the Citi Benefits Center once you lose eligibility. Once this is received, you may call MetLife directly at **+1 (877) 275-6387**.

Basic AD&D insurance may be continued without the need of a medical exam. Once notified of your loss of eligibility, MetLife will send you information on how to continue coverage. Note that rates will be higher than Citi's group rate. If you have any questions about continuing your Basic AD&D on an individual basis, call MetLife directly at **+1 (888) 252-3607**.

If you become ineligible for Basic Life and Basic AD&D coverage because your benefits eligible pay for the plan year equals or exceeds US($)200,000, you can also continue your Basic Life and/or Basic AD&D coverage on an individual basis, without providing evidence of good health, by calling MetLife within 31 days after you become ineligible.

Group Universal Life (GUL) Insurance

You can enroll in GUL insurance provided by MetLife for yourself from one to 10 times your benefits eligible pay, not to exceed US($) $500,000, up to a maximum of US($) 5 million. If your benefits eligible pay is not an even multiple of US($) 1,000, it will be rounded up to the next US($) 1,000.

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

If you are enrolling for the first time as newly eligible and you are enrolling (i) within your initial eligibility period of 31 days of your eligibility date or (ii) for an amount no greater than three times your benefits eligible pay (not exceeding US($) 500,000 or US($) 1.5 million), or(iii) as a result of a qualified change in status, you will not be required to provide evidence of good health by completing an evidence of insurability questionnaire or undergoing a physical exam. Please note if you are enrolling otherwise, you will be required to provide evidence of insurance and the increased amount of coverage will be effective upon approval by MetLife up to the maximum allowable amount.

"Actively at work" means that you are regularly scheduled to work in the office or at home and you are not away from work due to a disability. You must be able to perform all the activities of your job.

Enrolling in GUL Insurance Coverage

The enrollment process for GUL insurance is handled directly with MetLife and not the Citi Benefits Center. To enroll in GUL coverage for you and/or your spouse/partner, you must submit an enrollment form. You can download the form from the Expatriate Program Support page of the *Citi For You* website or you can call MetLife at +1 (888) 830-7380 for the form. The enrollment period to enroll in GUL coverage is 31 days from your initial transfer date.

If your benefits eligible pay is reduced, your GUL amount will continue to be based on the higher benefits eligible pay unless you call MetLife to request that the GUL amount be reduced. Once you reduce coverage, you can increase it by reinstating the automatic benefits eligible pay or purchasing additional multiples of your benefits eligible pay. You may be asked to provide satisfactory evidence of good health before the increased coverage will become effective. GUL coverage for an employee ends at age 95.

If you leave Citi, your GUL coverage may be continued under an individual policy. MetLife will send you information regarding the continuation of your GUL coverage once notified of your termination or retirement. If you continue your GUL coverage, MetLife will bill you directly at a higher rate than the Citi group insurance rate. The rate will become effective in the month following your termination of employment or transfer. If you have any questions on continuing your coverage, call MetLife directly at +**1 (888) 830-7380**.

GUL Accelerated Benefits Option (ABO)

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

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

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

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

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

Accelerated benefits are not payable if:

- You have assigned the death benefit;
- All or a portion of your death benefit is to be paid to your former spouse as part of a divorce agreement.
- You attempt suicide or injure yourself on purpose;

- The amount of your death benefit is less than US($) 15,000; or
- You are required by a government agency to request payment of the accelerated benefit so you can apply for, obtain or keep a government benefit or entitlement.

Cash Accumulation Fund (CAF)

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

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

If your contributions for GUL, including the CAF, exceed the actual limits of the coverage for which you are enrolled, MetLife will notify you about a refund. For the actual amount that applies to you under applicable tax laws, call MetLife at +**1 (888) 830-7380**.

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

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

For more information about the CAF, call MetLife at +**1 (888) 830-7380**.

Coverage for Your Spouse/Partner

You can buy GUL coverage for your spouse/partner in increments of US($) 10,000 to a maximum of US($) 100,000. You do not need to buy GUL coverage for you to elect coverage for your spouse/partner.

Within 31 days of your initial eligibility or as a result of a qualified change in status, you can enroll for up to US($) 30,000 of spouse/partner coverage without your spouse/partner having to provide evidence of good health.

If you enroll at any other time, your spouse/partner will have to provide evidence of good health for *any* amount of spouse/partner coverage. The cost of coverage is based on the amount of coverage you elect, your spouse's/partner's age and whether he/she has used tobacco products in the last 12 months. You can also open a CAF in your spouse's/partner's name.

If you leave Citi, or terminate your marriage or partnership, your spouse/partner can still continue coverage. MetLife will bill him or her directly at a higher rate than the Citi group insurance rate. The rate will become effective in the month following your termination of employment, divorce or termination of your marriage or partnership.

Coverage for Your Children

If you have enrolled in GUL insurance coverage for you or your spouse/partner, you can enroll your eligible dependent children for term life insurance from US($) 5,000 to US($) 20,000, in US($) 5,000 increments. Life insurance coverage is provided by MetLife. To enroll in child life coverage, call MetLife at +**1 (888) 830-7380**.

When you enroll in child life coverage, all your eligible children are covered. You may enroll your eligible children in GUL coverage at any time without evidence of insurability. Coverage for a child generally ends the day on which the child reaches the age of 27, or earlier if you lose eligibility for coverage.

Separately, you must report the birth or adoption of each child to the Citi Benefits Center within 31 days of the birth or adoption. Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Unless you have designated a beneficiary — other than yourself — to receive these benefits, benefits will be paid to:

- You, if you survive the dependent; or
- Your estate, if the dependent dies at the same time your death occurs; or
- Your estate, if the dependent dies within 24 hours after your death.

You may designate or change your beneficiary for life insurance for your child at any time by calling MetLife at +1 (888) 830-7380.

Naming a Beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or change your beneficiary for GUL insurance at any time by calling MetLife at +1 (888) 830-7380.

Your spouse/partner must call MetLife at +1 (888) 830-7380.

If there is no beneficiary designated or no surviving beneficiary at your death, MetLife will determine the beneficiary in the following order:

- Your spouse, if alive;
- Your child(ren), if there is no surviving spouse;
- Your parent(s), if there is no surviving child;
- Your sibling(s), if there is no surviving parent; or
- Your estate, if there is no surviving sibling.

If a beneficiary or payee is a minor or incompetent to receive payment, MetLife will pay his or her guardian.

Supplemental AD&D Insurance

You may enroll in Supplemental AD&D coverage, provided by MetLife, without providing evidence of insurability. You may choose from one to 10 times your benefits eligible pay up, not to exceed US($) 500,000, to a maximum coverage amount of US($) 5 million. If your benefits eligible pay is not an even multiple of US($) 1,000, then your benefits eligible pay will be rounded up to the next US($) 1,000. Your cost is based on coverage you elect. If your benefits eligible pay is reduced, your Supplemental AD&D amount will continue to be based on the higher benefits eligible pay unless you call MetLife at +1 (888) 830-7380 to request that the Supplemental AD&D amount be reduced.

Enrolling in Supplemental AD&D Insurance Coverage

The enrollment process for Supplemental AD&D insurance is handled directly with MetLife and not the Citi Benefits Center. To enroll in Supplemental AD&D coverage for you and/or your spouse/partner, you must submit an enrollment form. You can download the form from the Expatriate Program Support page of *Citi For You* or you can call MetLife at 1 (888) 830-7380 for the form. The enrollment period to enroll in Supplemental AD&D coverage is 60 days from your initial transfer date.

Once you reduce coverage, you can increase it by reinstating the automatic benefits eligible pay increase or by purchasing additional multiples of your benefits eligible pay.

You can enroll in Supplemental AD&D insurance coverage, provided by MetLife, for your spouse/partner in increments of US($) 10,000 to a maximum of US($) 100,000, without providing evidence of insurability at any time. You do not need to buy Supplemental AD&D insurance for you to elect coverage for your spouse/partner. You may enroll your spouse/partner for Supplemental AD&D coverage at any time without providing evidence of insurability.

You may enroll your eligible children in Supplemental AD&D coverage at any time without evidence of insurability. Coverage for a child generally ends the day on which the child reaches the age 27, or earlier if you lose eligibility for coverage.

If you leave Citi or terminate your marriage or partnership, you and your spouse/partner and children may continue coverage by paying premiums directly to MetLife. If you continue coverage, MetLife will bill you at a higher rate than the Citigroup insurance rate effective the month following the loss of eligibility. If you have any questions on coverage continuation, call MetLife directly at +**1 (888) 252-3607**.

Claims and Appeals Information

Procedures for Presenting Claims for Benefits

All claim forms needed to file for benefits under the group insurance program can be obtained from the Citi Benefits Center who will also be ready to answer questions about the insurance benefits and to assist you or, if applicable, the claimant in filing claims. The instructions on the claim form should be followed carefully. This will expedite the processing of the claim. Be sure all questions are answered fully.

The completed claim form should be returned to the Citi Benefits Center who will certify that you are insured under the Plan and will then forward the claim form to Metropolitan.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Routine Questions

If there is any question about a claim payment, an explanation may be requested from the Citi Benefits Center who is usually able to provide the necessary information.

Requesting a Review of Claims

In the event a claim has been denied in whole or in part, you or, if applicable, the claimant can request a review of your claim by Metropolitan. This request for review should be sent to Group Insurance Claims Review at the address of Metropolitan's office which processed the claim within 60 days after you or, if applicable, the claimant received notice of denial of the claim. When requesting a review, please state the reason you or, if applicable, the claimant believe the claim was improperly denied and submit any data, questions or comments you or, if applicable, the claimant deems appropriate.

Metropolitan will re-evaluate all the information and you or, if applicable, the claimant will be informed of the decision in a timely manner.

Business Travel Accident/Medical (BTA/BTM) Insurance

BTA/BTM pays benefits for bodily injury and/or death when a covered accident is incurred while traveling on company business. In addition to BTA, the BTM program provides non-routine and emergency medical coverage while traveling on business for Citi outside of your assigned country.

Coverage is provided by Chubb.

- All regular full-time and part-time employees have BTA coverage equal to five times their benefits eligible pay to a maximum benefit of US($) 2 million. Your spouse/partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip. An eligible spouse/partner has a coverage amount of US($)150,000.
- Each eligible dependent child (up to age 26) has a coverage amount of US($) 25,000.

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

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

Your BTA beneficiary — the person or persons designated to receive any benefit payable at your death — is the same beneficiary designated for your Basic Life insurance. If you do not have Basic Life insurance, you can designate a beneficiary by visiting Your Benefits Resources™. You can link to Your Benefits Resources™ through My Total Compensation and Benefits at **www.totalcomponline.com**. Otherwise, the beneficiary is your spouse/partner, then your children, and then your estate.

Converting to an Individual Policy

You can convert your BTA coverage to an individual Accidental Death and Dismemberment (AD&D) policy within 31 days of your termination of employment from Citi if you are under age 70 and you submit an application and the appropriate premium. The coverage under the individual policy must be for at least US($) 25,000 and cannot be more than the greater of the amount of your employee coverage or US($) 500,000. Coverage for an employee ends when the employee is no longer considered to be benefits-eligible under the terms of the policy.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA), a U.S. federal law, 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 (called “qualifying events”) where coverage under the plan would otherwise end. The Citi plans for Expatriates that are subject to COBRA are the Citi Expatriate Medical Plan and the Citi Expatriate Dental Plan (collectively the “Health Plans”).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

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

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

You must pay the entire contribution (employee plus employer) plus a 2% administrative fee for your continuation coverage. You first payment is due within 60 days of the date in which you elect coverage.

Who Is Covered

You and your family have a right to choose this continuation coverage if:

- You are enrolled in the Citi Expatriate Medical or Citi Expatriate Dental Plan; and
- You lose your group health coverage because of a reduction of work hours of employment or from 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 U.S. Family and Medical Leave Act (FMLA), the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave or do not return to work after the leave or (b) the last day of the FMLA leave period.

Note that effective January 1, 2024, if you elect continuation of coverage under COBRA, your coverage will depend on your place of residence. If you remain living outside of the United States, Puerto Rico or Canada, you will be offered COBRA coverage under the Citi Expatriate medical or Citi Expatriate Dental Plan (Aetna International Plan). If you return to the U.S. and you are COBRA eligible, you may continue coverage under the Citigroup Medical Plan or Dental Plan for U.S. employees. The law requires that you be provided with the opportunity to maintain continuation coverage for up to 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

If you are the spouse/partner of an employee and are covered by the Citi Expatriate Medical Plan or Citi Expatriate Dental Plan and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

- The death of your spouse/partner;
- The termination of your spouse's /partner's employment (for reasons other than your spouse's/partner's gross misconduct) or a reduction in your spouse's/partner's hours of employment;
- Divorce or legal separation from your spouse; or
- Your spouse's/partner's entitlement to Medicare.

If you are a covered dependent child of an employee covered by the Citi Expatriate Medical Plan or Citi Expatriate Dental Plan on the day before the qualifying event and you lose coverage under a Citi-sponsored group health plan for any of the following five reasons, you also are a qualified beneficiary and have the right to continuation coverage:

- The death of the employee;
- The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
- The employee's divorce or legal separation;
- The employee's entitlement to Medicare; or
- You cease to be a "dependent child" under the Citi-sponsored medical or dental plans.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage, the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of U.S. federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate Elections

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

If you terminate employment following a leave of absence qualifying under the U.S. Family Medical Leave Act (FMLA), the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of the date that you indicated you will not be returning to work following the leave or the last day of the FMLA leave period.

Electing COBRA

To inquire about COBRA coverage, call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Several weeks after your COBRA-qualifying event, you will automatically receive COBRA election information from Citi's COBRA administrator. Citi considers the date of the qualifying event as the day your employment terminated or another qualifying event occurred. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described previously, or, if later, 60 days after Citi provides notice of your right to elect continuation coverage. An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

If you elect continuation coverage, Citi is required to give you coverage that, as of the time coverage is being provided, is identical to coverage provided under the health plans to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will be modified too. "Similarly situated" refers to a current employee or dependent who has not had a qualifying event.

Duration of COBRA

The law requires that you be provided with the opportunity to maintain continuation coverage for up to 18 months if you lose group health coverage because of a termination of employment or a reduction in work hours.

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

Additional qualifying events (such as a death, divorce, legal separation or Medicare entitlement) or a dependent child's loss of dependent status after an initial qualifying event (such as loss of employment) may occur while the continuation coverage is in effect. These events can result in an extension of an 18-month continuation period to 36 months, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified dependent eligible to elect coverage. You should notify Citi if a second qualifying event occurs during your continuation coverage period.

Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

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

Special Rules for Disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the U.S. Social Security Administration (SSA) to be disabled at any time during the first 60 days of continuation coverage. For Expatriates in locations where laws applicable to the U.S. Social Security Administration do not apply, it will be necessary for you to contact Aetna International to review your or your family member's medical history so it can make a determination of benefits.

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

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

Medicare

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

Early Termination of COBRA

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

- Citi's policy changes and no longer provides group health coverage to any of its U.S. employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- The person who elected COBRA becomes covered after COBRA is elected under another group health plan (whether or not as an employee);
- The person who elected becomes entitled to Medicare after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and a final determination is made by the disability carrier that the individual is no longer disabled.

COBRA and FMLA (for Active employees only)

A leave that qualified under the U.S. Family and Medical Leave Act (FMLA) does not make you eligible for COBRA coverage. However, regardless of whether you lost coverage because of non-payment of premiums during an FMLA

leave or you decide not to return to active employment, you are still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

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

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

- You or your spouse/partner and/or dependent child is covered by the Plan on the day before the leave begins; and
- You do not return to work at the end of the FMLA leave.

Your Duties

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

- A divorce or legal separation;
- Termination of a partnership;
- The loss of a child's dependent status under the Citi Expatriate Medical or Dental Plan;
- An additional qualifying event (such as a death, divorce or legal separation) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the U.S. Social Security Administration (SSA) that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage of 18 months; or review and approval by Aetna International in situations where SSA would not apply; A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice *must* be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status or an additional qualifying event. In the case of a disability determination, the notice must be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage.

If the employee or a family member fails to provide this notice to Citi during this period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

How to Report a Change to Your Current Coverage/Life Event

- Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.
- Visit YBR™ directly through My Total Compensation and Benefits at www.totalcomponline.com using your Single Sign On.

When Citi is notified that one of these events has happened, Citi, in turn, will notify you that you can elect continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, then you and your family members must reimburse the Plans for any claims mistakenly paid.

Citi's Duties

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

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

Cost of Coverage

Under U.S. law, you may be required to pay up to 102% of the premium for your continuation coverage. If your coverage is extended from 18 to 29 months for disability, you will be required to pay 150% of the premium beginning with the 19th month of continuation coverage.

The cost of group health coverage periodically changes. If you elect continuation coverage, Citi will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way.

The initial payment for continuation coverage is due 60 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 60 days from the bill due date.

If you have any questions about COBRA coverage or the application of the law, please contact the COBRA administrator at the address listed at the back of the book. If the covered person has terminated employment with Citi and your marital status has changed or you or a qualified beneficiary has changed addresses or a dependent ceases to be a dependent eligible for coverage under the terms of the Plan, you must notify the COBRA administrator.

All notices and other communications regarding COBRA and the Citi-sponsored group health plan should be directed to the Citi Benefits Center. Call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam).From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

When Coverage Ends

Your coverage under the Citi Expatriate Medical and Dental Plans (collectively, the "Plans") will terminate automatically on the earliest of the following dates:

- The date the Plans are terminated;
- The last day for which the necessary contributions are made; If you cease making contributions to the Plans, you are ineligible for coverage;
- The effective transfer date you are removed from the Expatriate Program
- Midnight of the day your employment is terminated (unless you have attained age 65. If you attained age 65, your coverage will end at midnight on the last day of the month in which your employment terminated), your assignment ends or you otherwise cease to be eligible for coverage;
- The day you die;
- To the extent applicable, the date benefits paid on your behalf equal the lifetime maximum benefit under the Plans for such category of benefits; or

- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

Basic Life insurance, Basic AD&D insurance, Short-Term Disability and Long-Term Disability coverage end on the date your employment is terminated or you transfer to local staff, repatriate to your sending country.

GUL insurance and Supplemental AD&D insurance coverage ends on the last day of the month in which your employment terminates or you transfer to local staff repatriate to your sending country.

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

- Midnight on the day in which your coverage is terminated (an exception is your death, in which case coverage will continue for six months if covered survivors elect COBRA), unless you have attained age 65. If you attained age 65, your coverage will end at midnight of the last day of the month in which your employment terminated;
- The date you elect to terminate your eligible dependent's coverage as a result of a qualified change in status;
- The date you become legally separated, divorced, submit a partnership termination form or submit other legal documents showing your termination of the relationship with your partner;
- The last day for which the necessary contributions are made;
- The last date your eligible dependent ceases to be eligible for coverage (coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age);
- The date your eligible dependent is covered as an employee under the Citigroup Health and Insurance Plans;
- The date your eligible dependent enters the armed forces of any country or international organization;
- The date your dependent is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO); The date defined in the dependent verification package if proof of eligibility is not received by the deadline; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefit Plan; in such an event, coverage may be terminated retroactively.

Coverage if You Localize After Your Expat Assignment Ends on or before December 31, 2023

If you decide to (or are required to) stay in the location of your expat assignment after your assignment ends, you may elect to continue your coverage under the Plans for as long as you remain a benefits-eligible Citi employee. **However, you must make such an election on or before December 31, 2023 to have such coverage**. If you elect this option, you will pay the entire contribution (employee plus employer) plus a 2% administrative fee for your continuation coverage.

Note: If you elect this option, you will pay the same premium as individuals who continue coverage under COBRA. However, this is not COBRA coverage. It continues as long as you elect such coverage, and continue to be a benefits-eligible Citi employee, if you have made such an election on or before December 31, 2023. **There will be no new enrollees in this coverage after December 31, 2023.**

Employees currently on continuation of coverage will be allowed to remain on this coverage indefinitely.

Coverage for Surviving Dependents

When an active employee dies while on expatriate assignment, the surviving spouse/partner and/or dependent children who were enrolled in active expatriate medical and or dental coverage at the time of the employee's death

will be eligible to continue health care coverage under the expatriate medical and/or dental plans through COBRA for six months at no cost. For your surviving spouse/partner and/or dependent children to have six months of free medical and/or dental coverage, they must elect COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center within the election period. Please note: only the first six months of COBRA coverage is free to the surviving spouse/partner and/or dependents. The remaining continuation of COBRA coverage period is payable as discussed beginning on page 87, explaining the cost of COBRA.

Coverage if You Become Disabled

If you are disabled, you and your eligible dependents may continue medical and dental coverage for up to 52 weeks, including the 13-week period of STD, as long as you make the active employee contributions. After the 13-week paid STD period, the Citi Benefits Center will bill you for your benefits. The cost is not deducted from your LTD benefit.

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

MetLife, the Disability claims administrator, will medically manage your disability if you are a totally disabled employee who has been denied LTD benefits due to a pre-existing condition, did not enroll in LTD coverage (pursuant to the plan terms on your hire date), or who has reached the maximum benefit under the two-year limitation rule as described in the LTD plan documents.

Medical Coverage

Coverage will continue for 52 weeks, including the 13-week period of Short-Term Disability (STD), as long as you pay the active employee contributions.

If you became disabled prior to January 1, 2014:

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

For the purposes of the Disability Plan, a year of service is each twelve (12) months of service, counting any part of a month in which you provided service. Service before a break in service will be allowed (or not) under the rules similar to the Citigroup Pension Plan credited service such as not counting service prior to five consecutive one year breaks in service. In no event will the time between your periods of Citi service be counted.

Years of Citi Service (as of the LTD effective date)	Medical Continuation Period After Week 52 (the termination of your employment)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you are deemed disabled and eligible for LTD benefits under the Plan.

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

If you became disabled on or after January 1, 2014:

If you became disabled on or after January 1, 2014, and

- commence short-term disability benefits;
- you receive disability benefits for 52 weeks (including LTD benefits); and
- your employment is terminated,

you will be eligible to pay the same rate that active employees pay for medical coverage for up to thirty-six (36) months after your employment terminates, regardless of your years of service with Citi.

At the end of the medical continuation period, you may continue coverage through COBRA for up to 29 months, if applicable.

Dental Coverage

Dental coverage will continue for 52 weeks (including the 13-week STD period). After 13 weeks, the Citi Benefits Center will bill you directly. After your employment is terminated, you may continue coverage under COBRA.

Basic Life, Basic AD&D, Group Universal Life (GUL) and Supplemental AD&D Insurance

Basic Life and Basic AD&D coverage stops after 52 weeks, but you can continue this coverage to an individual policy by calling the Citi Benefits Center through ConnectOne. From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Your GUL coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue GUL insurance. MetLife will bill you at the active rate for the lesser of a length of time based on your service or the length of your disability, as shown in the previous table. Your Supplemental AD&D coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits. You can convert your Supplemental AD&D coverage to an individual policy within 31 days after your employment terminates. For additional information contact MetLife at +**1 (888) 830-7380**.

Health and Insurance Benefits for Expatriate Retirees

Eligibility and Participation

This section of the SPD provides important information about eligibility, enrollment and participation in your Citi Retiree Expatriate health benefits.

Eligibility and Dependent Information

You are eligible to be enrolled in Retiree Expatriate health benefits if you meet the retiree health plan eligibility requirements and you are classified as a retiree of Citi or a participating business who is living outside of the United States, Puerto Rico or Canada. If eligible, your eligible dependents (defined below) may also be enrolled in the applicable plan.

In general, to be eligible for the Citigroup Retiree health plan:

- You must have been eligible for coverage as an active employee immediately prior to retirement, regardless of whether you were enrolled;
- You must have attained age 50, with at least five years of service; and
- Your age plus years of service equal at least 60.

In addition, you may be eligible for retiree coverage under the Aetna International medical and dental plans if you are an eligible Citi retiree who is actively enrolled in the Citigroup U.S. retiree benefit plans and you move outside of the

United States, Puerto Rico or Canada. In such a case, you will be eligible to change your coverage to the Citi-sponsored Aetna International plans.

Please note if you or your covered dependents have a change in residence that is within the United States, Puerto Rico or Canada, you will no longer be considered eligible for the Citi Expatriate (or Citi Aetna International plan) retiree coverage as described in this SPD.

If you retire while on Expatriate assignment, meet the eligibility requirements for the Citigroup retiree health plans and choose to return to the United States, Puerto Rico or Canada, you will be eligible for the Citigroup domestic retiree health plans. If you decline coverage under the retiree plans and you were previously enrolled in expatriate medical and/or dental coverage, you may continue coverage under the Citi expatriate plans by electing COBRA.

A Note for Employees Who Were Involuntarily Terminated

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

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

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

If you are involuntarily terminated, and you are eligible for the retiree health plans (or the expatriate health coverage) on your termination date, you must choose between electing retiree health coverage, as currently available or continuing health coverage through COBRA. If you elect COBRA, you will not be able to elect retiree health coverage at a later date.

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

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

If you have questions about eligibility for retiree health or expatriate plan coverage, call the Citi Benefits Center. If you have questions about plan benefits or claims, contact your insurance provider.

If Both You and Your Spouse/Partner Worked for Citi

If you and your spouse/partner were employed by Citi, each of you may be covered under the Plans as either a retiree or a dependent, but not both. You may pick one plan to cover both of you, or you may each elect your own plan. Either of you may cover your children, but they cannot be covered by both of you.

Definition of Eligible Dependents

You must provide proof of your dependents' eligibility for coverage if you are enrolling them in Citi plans for the first time ("newly added" dependents). Specifically, you will be prompted to submit the appropriate documentation, such as a copy of your government-issued birth certificate and marriage license, copies of passports/visas for each dependent, and/or tax return to ensure your newly added dependents' coverage is not canceled and their claims are paid.

Your eligible dependents are:

- Your lawfully married spouse (regardless of gender), or common-law spouse if you are a U.S. citizen or a permanent resident of the U.S. and your home state recognizes common-law marriages, or your civil union partner/domestic partner ("hereafter referred to as "partner"), if you live in a U.S. state that recognizes such partnerships. If you are legally separated, divorced or ended your partnership, your spouse/partner is *not* an eligible dependent unless mandated by state law; at any time you cannot cover more than one person as a spouse/ partner;
  - **Note:** Because civil union partnerships registered domestic partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships and registered domestic partnerships are not subject to the domestic partnership certification process, which is required if your partnership is not registered. However, under U.S. federal law, all partnerships are subject to the same tax treatment.
  - When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, certification of domestic partnership (satisfying the requirements set forth later in this document) or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways.
  - Your partner;
- Your partner's eligible dependents;
- Your children under the age of 26 (as of December 31 of the plan year that precedes the year in which the coverage applies) who are:
  - Your biological children;
  - Your legally adopted children (for purposes of coverage under the plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first);
  - Your stepchildren; and
  - Any other child for whom you are the legal guardian in accordance with the laws of the state in which you reside.

You can cover your disabled child beyond age 26 if he or she was covered under the plan before age 26 and became incapable of self-sustaining employment due to a disability while covered, in which case the eligible dependent may be eligible for coverage beyond such age.

You may also cover your disabled adult child age 26 or older who was disabled when you began employment with Citi and you enrolled him or her when you were first eligible to do so. You must have a letter from the U.S. Social Security Administration stating that your child is disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your benefits

Note: Your married child's spouse and children are not eligible for Citi coverage.

For Expatriates in locations where laws applicable to the U.S. Social Security Administration do not apply, it will be necessary for you to contact Aetna International to review your child's medical history so Aetna International can make a determination of benefits.

No dependent can be covered under these plans as both an employee and as an eligible dependent or as an eligible dependent of more than one employee.

Dependent Verification Process

After you are auto enrolled, or when you add an eligible dependent to your coverage due to a change in status, you are required to submit proof of the dependent's eligibility for coverage (for example, a copy of your government-issued marriage license, children's birth certificate, passport, visa or rental agreement). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from your coverage.

You must also keep your dependent information current.

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

Disabled Children

If your eligible dependent child is permanently and totally disabled as defined for purposes of obtaining U.S. Social Security benefits and (a) is covered under the Plans before reaching the applicable maximum age as described above, or (b) you enroll this dependent within the first 31 days of your eligibility under the Plans, this child may continue to be considered an eligible dependent under the Plans beyond the date his or her eligibility for coverage would otherwise end. You must provide written proof of this incapacity to the Claims Administrator within 31 days after the date eligibility would otherwise end or as requested thereafter. This eligible dependent must still meet all other eligibility qualifications to continue coverage, including, but not limited to, continuing to be permanently and totally disabled.

Enrolling in Your Retiree Benefits

Your "retirement" date under the Plans is the date when you terminate employment with Citi and you are eligible for retiree coverage.

When you retire and if you are eligible, you will receive information about the Plans. The options available to you will be listed on your Personal Enrollment Worksheet along with your enrollment deadline and instructions on how to enroll. Generally, you are required to elect coverage under Citi expatriate retiree medical and dental plans (the "Expatriate Retiree Health Plans") within the time indicated in your enrollment package**. If you do not elect coverage during that time period, you will not be permitted to enroll at a later date.**

Annual enrollment will provide retiree coverage on a calendar year basis, January 1 through December 31. Retirees will be provided with an annual enrollment period during the Autumn of each year to elect benefits for the following calendar year

COBRA Election/Waiver of Expatriate Retiree Health Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, ("COBRA") is a federal law requiring that most employers who sponsor group health plans offer to employees and eligible dependents the opportunity for a temporary extension of active health coverage (called "continuation coverage") at group rates in certain instances (called "qualifying events") when coverage under the plans would otherwise end. Note that continuation coverage through COBRA is only available under the group health plan in which you are enrolled at the time of the qualifying event. For example, if you are enrolled in the Expatriate medical and dental plans, you cannot elect COBRA coverage under the Citigroup U.S. medical and dental plans, or vice versa.

The following provisions of COBRA apply if you elect continuation coverage through the Citi expatriate medical and dental plans (the "Expatriate Health Plans") and waive coverage under the Expatriate Retiree Health Plans: You must elect coverage under the Expatriate Retiree Health Plans (within the time indicated in your enrollment package), which may be before you are required to elect COBRA (generally, within 60 days after your employment is terminated or, if later, 60 days from the day the COBRA information is sent to you). *Be mindful of this timing difference in making your election.* The provisions of COBRA, noted later in this document, are applicable if coverage under the Expatriate Retiree Health Plans is elected.

You may elect to continue the Expatriate Health Plans you had as an active employee under COBRA. In general, if you are eligible for coverage under the Expatriate Retiree Health Plans upon your retirement or termination of employment and you elect COBRA continuation coverage, you will waive your right to coverage under the Expatriate Retiree Health Plans.

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

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

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

You must pay the entire contribution (Citi's contribution and the employee contribution) plus a 2% administrative fee for continuation coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled contribution. Your initial payment must be made within 60 days of the date you make your election.

Who Is Covered Under COBRA

You have a right to choose continuation coverage if:

- You are enrolled in active Citi expatriate medical and expatriate dental coverage and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you are the spouse/partner of an employee and are covered by an active Citi-sponsored expatriate medical and expatriate dental plan and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

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

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

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

- The employee's divorce or legal separation;
- The employee's entitlement to Medicare; or
- You cease to be a "dependent child" under the Citi-sponsored expatriate medical and expatriate dental plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage the new child is also eligible to become a qualified beneficiary.

According to the terms of the employer-sponsored group health plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate Elections

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

Electing COBRA

To inquire about COBRA coverage, call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

Several weeks after your COBRA-qualifying event, you will automatically receive COBRA election information from Citi's COBRA administrator. Citi considers the date of the qualifying event as the day your employment terminated or another qualifying event occurred. Under the law, you must elect continuation coverage within 60 days from the date you lost coverage as a result of one of the events described previously, or, if later, 60 days after Citi provides notice of your right to elect continuation coverage.

An employee or family member who does not choose continuation coverage within the time period described above will lose the right to elect continuation coverage.

If you elect continuation coverage, Citi is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. If the coverage for similarly situated employees or family members is modified, your coverage will also 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 lose group health coverage because of a termination of employment or a reduction in work hours.

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

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

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

Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

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

Special Rules for Disability

The 18 months may be extended to 29 months if the employee or covered family member is determined by the Social Security Administration (SSA) to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage. For Expatriates in locations where laws applicable to the U.S. Social Security Administration do not apply, it will be necessary for you to contact Aetna International to review your or your family member's medical history so it can make a determination of benefits.

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

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

Medicare Entitlement

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

Early Termination of COBRA

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

- Citi 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 pre-existing condition of the 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 the SSA makes a final determination that the individual is no longer disabled.

Your Duties

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

- A divorce or legal separation;
- The loss of a child's dependent status under the expatriate medical and expatriate dental plan;
- An additional qualifying event (such as a death, divorce or legal separation) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the U.S. Social Security Administration (SSA) that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage of 18 months; or review and approval by Aetna International in situations where SSA would not apply; or
- A subsequent determination by the SSA that the employee or family member is no longer disabled.

This notice *must* be provided within 60 days from the date of the divorce, legal separation, a child's loss of dependent status, or an additional qualifying event. In the case of a disability determination, the notice *must* be provided within 60 days after the SSA's disability determination and before the end of the initial 18-month continuation coverage period.

If the employee or a family member fails to provide this notice to Citi during this notice period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

The notice must be in writing and must include the following information:

- The applicable Plan name;
- The identity of the covered employee and any qualified beneficiaries;
- A description of the qualifying event or disability determination;
- The date on which it occurred; and
- Any related information customarily and consistently requested by Citi's COBRA administrator.

When Citi is notified that one of these events has occurred, Citi, in turn, will notify you that you have the right to elect continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, then you and your family members must reimburse the Plans for any claims mistakenly paid.

How to Report a Change to Your Current Coverage/Life Event

Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option. > Visit YBR™ directly through My Total Compensation and Benefits at www.totalcomponline.com using your Single Sign On. When Citi is notified that one of these events has happened, Citi, in turn, will notify you that you can elect continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, then you and your family members must reimburse the Plans for any claims mistakenly paid.

Citi's Duties

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

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

Cost of COBRA 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, Citi will notify you of any changes in the cost. If coverage under the Plan is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way.

The initial payment for continuation coverage is due 60 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.

For More Information About COBRA Coverage

If you have any questions about COBRA coverage or the application of the law, contact Citi's COBRA administrator at the address below. If the covered person has terminated employment with Citi and your marital status has changed or you or a qualified beneficiary has changed addresses or a dependent ceases to be a dependent eligible for coverage under the terms of the Plans, you must notify the COBRA administrator in writing immediately at the address below.

All notices and other communications regarding COBRA and the Citi-sponsored group health plan should be directed to the Citi Benefits Center. Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

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

Please note you may have options other than the COBRA continuation of health benefits available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The day after your employment terminates and you are ineligible for coverage under the Citi health plan, there is a 60-day special enrollment period during which you can enroll for coverage in the Health Insurance Marketplace. If you are considering enrolling for coverage under the Exchange, be mindful of this enrollment deadline.

How to Review Your Benefits Online

To review your benefits, visit the Your Benefits Resources™ (YBR™) website through My Total Compensation and Benefits at www.totalcomponline.com.

- **Expatriates** can log on using their User ID and Single Sign-on.

For Technical Issues if you need assistance accessing My Total Compensation and Benefits at www.totalcomponline.com, call +1(888)-630-7913 if you are calling within the U.S. For International callers please call +1(480)-712-4745.

Reminder

If web issues prevent you from accessing your information online, you can call the Citi Benefits Center.

Once enrolled in health coverage, you will have the opportunity to change your elections during the Annual Enrollment period for the following plan year. If you do not make any changes during the Annual Enrollment period, you will be assigned the same coverage the following plan year, beginning January 1.

After You Enroll

Confirmation Statement

A couple of weeks after you enroll, you will receive a confirmation of your enrollment from the Citi Benefits Center via email. You can also view your auto enrollment on-line by visiting the Your Benefit's Resources™ (YBR™) website, available through My Total Compensation and Benefits.

If you find an error, call the HR Shared Services (HRSS) North America Service Center immediately at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option.

Updating Your Home Address

Important information — such as medical ID cards — will be mailed to your home address on file according to Citi's records.

To update your home address by calling the HR Shared Services (HRSS) North America Service Center immediately at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne main menu, choose the "health and insurance benefits" option.

The Cost of Your Retiree Benefits

Costs are shown on your Personal Enrollment Worksheet and, generally, increase each year. Cost for a domestic partner is the same as the cost of coverage for a spouse. The cost of coverage for a partner's child(ren) is the same as the cost for your dependent child(ren).

Retiree coverage is neither fixed or guaranteed under the Expatriate Retiree Health Plans. Citi reserves the right to amend, terminate, suspend or otherwise change the Plans provided to retirees at any time for any reason.

Call the Citi Benefits Center for more information on your premium payment options.

Coverage Categories

Citi offers four coverage categories. Your coverage category will be based on your dependent information received. If you need to change your coverage category due to a change in family status, contact the Citi Benefits Center.

- **Retiree only:** Coverage for you only;
- **Retiree Plus Spouse/Partner:** Coverage for you and your spouse/partner only;
- **Retiree Plus Child(ren):** Coverage for you and your eligible child(ren), including the eligible child(ren) of your spouse/partner; and
- **Retiree Plus Family:** Coverage for you, your eligible spouse/partner, your eligible children and your spouse's/partner's eligible children.

You can change your coverage category during the Annual Enrollment period and within 31 days of a qualified change in status. The cost of coverage in each of the above coverage categories varies and will be shown on your Personal Enrollment Worksheet.

Changing Your Coverage

In general, Plan coverage and the coverage category you choose when you first enroll remain in effect until you drop coverage or your participation otherwise ends.

You may cancel your coverage at any time. However, if you or your dependent drops coverage in a Health Plan you cannot re-enroll at a later date.

If you have any questions, speak to a Citi Benefits Center representative.

In general, if you choose to waive coverage under the Plans when initially eligible, you will not be able to enroll at a later date.

Partner Benefits

Citi offers benefits coverage to your partner.

You may cover your partner and his or her eligible child(ren) under the medical and/or dental plan.

You may enroll your partner and his or her eligible children in the medical and/or dental plan.

Note: Citi's Expatriate Medical Plan does not have a pre-existing condition limitation or exclusion that would prevent you from enrolling your partner in the Plan or from your partner receiving benefits for a specific condition or illness.

If both you and your partner are employed by Citi and are benefits-eligible, each of you can elect coverage individually or one of you can enroll and claim the other as a dependent. You cannot enroll as an individual and be claimed as your spouse's/partner's dependent.

When You Can Enroll Your Partner in Citi Coverage

At any time, you cannot cover more than one person as your spouse/partner. To enroll a domestic partner in an unregistered domestic partnership and/or his/her children, you and your partner must first complete forms attesting to your domestic partnership. You can obtain the required documents by calling the Citi Benefits Center.

A domestic partner and his/her dependents must be enrolled upon your initial election. If you waive coverage for your domestic partner and, if applicable, his/her dependents upon your initial election, you will not be permitted to enroll the same domestic partner and his/her dependents at a later date. In addition, if you enter into a domestic partner relationship subsequent to your initial enrollment, such domestic partner and his/her dependent children shall not be eligible to enroll for benefits under the Plans.

The cost of coverage for a partner is the same as the cost for a spouse. The cost of coverage for a partner's child(ren) is the same as the cost for a dependent child.

Qualifications for Domestic Partnership

If your domestic partnership is registered in any state or under any local government authorized to provide such registration, your registration will be accepted as proof of your domestic partnership. If your domestic partnership is not registered, you will need to complete a form that certifies the following:

- You have lived together for at least six consecutive months prior to enrollment; if you are (were) married, legally separated or getting a divorce, the six months (to enroll your domestic partner) are counted beginning with the date your divorce is final or the date you report your divorce to the Citi Benefits Center, whichever is later;
- You are financially interdependent, or your partner is dependent on you for financial support;

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

Evidence of Financial Interdependence/Dependence

Citi may require you to provide evidence of your financial interdependence (or partner's financial dependence) by providing two or more of the following forms of documentation:

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

Cost of Partner Benefits

If your partner and his or her children:

- **Qualify as your dependents under U.S. tax law**, your contributions for partner medical and dental coverage will be deducted from your pay before taxes are withheld.
- **Do not qualify as dependents under U.S. tax law**, you will pay for their medical and dental coverage with after-tax dollars.

The cost of coverage for a partner is the same as it is for a spouse. The cost of coverage for a partner's child(ren) is the same as it is for a dependent child. You will find the cost to enroll in each coverage category on your Personal Enrollment Worksheet.

Hypothetical Tax Implications

Your hypothetical taxes may be affected when you enroll your partner in Expatriate benefits.

If Your Partner Does NOT Qualify as a Hypothetical Tax Dependent

If your partner and his or her child(ren) do not satisfy the definition of a hypothetical tax dependent, the full cost of any medical and/or dental coverage for your partner and/or his or her child(ren) is considered "imputed income." This amount will be shown on your pay statement and, if applicable, your Form W-2 for the year in which coverage was effective. You will pay hypothetical taxes on the amount of imputed income.

Example

Total Citi cost for employee-only coverage whose benefits eligible pay is US($) 200,001 is US($) 263 per month. Total Citi cost for employee + spouse/partner coverage is US($) 512.

The US($) 249 cost for partner coverage is considered imputed income, and you will pay hypothetical taxes on this amount.

If Your Partner Qualifies as a Hypothetical Tax Dependent

If your partner and his or her child(ren) qualify as hypothetical tax dependents, your contributions for their medical and/or dental coverage will be taken before hypothetical taxes are withheld and there are generally no additional tax costs to you.

A member of your household generally will qualify as your hypothetical tax dependent if:

- You provide more than 50% of his or her financial support;
- The individual receives less income than the U.S. Internal Revenue Service-allowed annual amount of gross income in any calendar year US($) 4,000 in 2016; and
- The individual lives with you for the entire year.

If You and Your Partner Marry

Report your qualified change in status to the Citi Benefits Center within 31 days after the date of marriage and request that the imputed income calculation and taxes be stopped. Otherwise, imputed income will continue to be considered in calculating hypothetical tax.

If You Terminate Your Partnership

You must complete and submit a Termination of Partnership Form to terminate partner coverage. Call the Citi Benefits Center to obtain the form. Hypothetical taxes paid on the imputed income are not refundable.

Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne “benefits” menu, choose the “health and insurance benefits” option.

Medical Coverage

Generally, you will pay less when you receive care outside or in the U.S. from a provider in the Aetna International network. When seeking care in the U.S., you will pay more out of your pocket if you use a provider who does not participate in the Aetna International network (an out-of-network provider). The Aetna International network is available in the U.S. only.

Aetna International

Aetna International ID Cards

After you are enrolled in the Expatriate Retiree Health Plans, you will receive an Aetna International medical/dental ID card for you and, if applicable, your family members. Each ID card will be specific to the member with coverage. ID cards can also be printed online. After your enrollment, please allow four to six weeks to receive these cards in the mail.

The ID cards you receive after your initial enrollment will be valid as long as you are enrolled. ID cards are not reissued annually, they do not expire and they are valid globally.

About Aetna International

Aetna International specializes in Expatriate retiree benefits. Aetna International's customer service representatives are available 24/7. AT&T's language line is available so you or your spouse/partner can use any language to speak with an Aetna International representative.

Aetna International Websites

Your secure Aetna International Member Website, also known as the Health Hub is available 24/7. With Aetna Health Hub, you can:

- Submit claims,
- Find care outside the U.S.,
- View/edit member details,
- View documents, and
- Elect recurring reimbursement election (RRE).

From the Aetna Health Hub, you will be automatically directed to the Aetna Navigator for various tasks such as:

- Viewing status of a claim/claim history,
- Finding care within the U.S., and
- Printing temporary ID cards.

To have access to these sites, you first must register on the Health Hub. To register:

- Go to www.aetnainternational.com.
- Click on the "Log In/ Register" button in the top right hand corner.
- Continue to "Log In / Register" in the drop down.
- Click "register" on the next screen.
- Enter the employee's first name, last name and date of birth, as prompted.
- Select "Aetna International Plan Member" under plan type.
- Enter your WID (which can be found on your ID card) under member ID.
- Accept terms & conditions.
- Click on "get started."
- Enter the employees email address. Proceed to create a username, password, and security question on the next screen.
- Click "continue."
- Select your destination country/city, preferred language and country of citizenship on the next screen.
- Click "register."

By registering for Aetna Health Hub, you will automatically be registered for the Aetna Navigator. Once logged in to either site, you can pass between the two sites without having to log in again

When to Use Aetna's Websites

- Use www.aetnainternational.com to find international providers, obtain health and security information for more than 200 countries and obtain translation guides for drug and medical terms in multiple languages.
- Use www.aetna.com to find U.S. providers, print ID cards, access personalized benefit information including electronic explanation-of-benefit notices and an itemized list of completed claims, and order prescription drug refills.

Choosing an Aetna International Provider

Inside the U.S.

You can obtain an Aetna provider directory by:

- Visiting Aetna's website at **www.aetna.com**; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

Physicians, hospitals and other health care providers contract with Aetna to provide services for a negotiated fee to members covered by Aetna health plans. You will commonly hear of physicians and hospitals referred to as either "in-network" or "out of network."

- "In-network" means that the physician or hospital is contracted with Aetna and will bill for negotiated rates established as part of the contract. Seeking care at an in-network provider usually means that you will pay less for the services you receive. You will also have lower out-of-pocket expenses when you use in-network providers in the U.S.
- "Out-of-network" means that the physician or hospital does not have a contract with Aetna and, therefore, is free to bill in accordance with its own fee schedule. Being able to seek care out of network may offer you more convenience when accessing care, but it could cost you more.

Outside the U.S.

When you are outside the U.S., this Plan acts as an "indemnity plan," meaning you can seek care from the provider of your choice. You will have to pay out of pocket for these services and then submit your claim to Aetna for reimbursement. For inpatient and some high-cost outpatient procedures outside the U.S., Aetna International may be able to arrange for payment directly to the facility so that you are required to pay only for your coinsurance at the time of service. Contact the Aetna International Service Center for more information.

You can obtain an Aetna provider directory by:

- Visiting Aetna's website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

Aetna International Partnership Countries

Aetna International has formed partnerships with local providers in the following three assignment countries:

- Brazil: Gama Saude
- Mexico: Sinergia Medica
- UAE: Allianz Orient

If you are assigned to any of these countries, you will receive:

- A welcome kit and member ID card from Aetna International to be used when you and your dependents incur medical expenses outside of your assignment country.
- A partnership company welcome kit and member ID when you seek care in your assignment country.

Additional information, such as a welcome letter, "What to Do When," and program guidelines for each of the partnership countries, can be found on the Expatriate Program Support page of the *Citi For You* website. Click on Expatriates, Benefits, then Aetna International.

Expatriate Retiree Medical and Prescription Drug Plan Coverage at-a-Glance

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Annual deductible • Individual • Maximum per family	 US($) 500 US($) 1,000	 US($) 1,000 US($) 2,000
Annual medical out-of-pocket maximum (includes deductible, medical coinsurance and medical copayments) • Individual • Maximum per family	 US($) 2,000 US($) 4,000	 US($) 4,000 US($) 8,000
Hospital services		
• Hospital inpatient • Semiprivate room and board • Doctors charges • Lab, Radiology and X-ray • Surgical care and anesthesia **Note:** In some countries, charges are based on room type	80% coverage after deductible	70% coverage after deductible
Outpatient • Surgical care • Lab and X-ray	80% coverage after deductible	70% coverage after deductible
Emergency room	**Outside the U.S.**: 80% coverage after deductible **In-Network in the U.S.**:$50 copay (50% coverage after deductible if not a true emergency)	$50 copay (50% after deductible if not a true emergency)
Urgent Care	80% coverage after deductible	70% coverage after deductible
Physician services		
Physician office visit	80% coverage	70% coverage after deductible
Specialist office visit	80% coverage	70% coverage after deductible
Maternity • Physician office visit • Hospital delivery	80% coverage	70% coverage after deductible
Wellness/preventive care benefits		
Child preventive physical exams (Children ages 0-22) Seven exams first year of life, three exams second and third years of life, and one exam per year thereafter to age 22	100% coverage (subject to frequency limits)	70% coverage, no deductible applies

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Adult preventive physical exams (Adults age 22-65) One exam per calendar year for ages 22-65; for ages 65+ one exam per calendar year includes immunizations	100% coverage (subject to frequency limits)	70% coverage, no deductible applies
Adult and child Immunizations	100% coverage	70% coverage, no deductible applies
Routine care (subject to frequency limits)		
Routine gynecological exams Includes one exam and Pap smear per calendar year	100% coverage	70% coverage, no deductible applies
Mammograms No age and frequency limits apply	100% coverage	70% coverage, no deductible applies
Prostate Specific Antigen (PSA) Includes one PSA per calendar year for males 40+	100% coverage	70% coverage, no deductible applies
Routine vision exam Includes dilation; limited to one exam every 12 months up to a US($) 70 calendar year maximum	**Outside the U.S:** 80% coverage after deductible **In-Network in the U.S.**:100% coverage	70% coverage, no deductible applies
Eyeglasses Includes one pair of frames plus lenses **Contact lenses** • Conventional • Disposal • Medically necessary	Up to US($) 200 reimbursement for frames, lenses and contact lenses every 12 months	Up to US($) 200 reimbursement for frames, lenses and contact lenses every 12 months
Mental health services		
Mental health inpatient coverage No limits	80% coverage after deductible	70% coverage after deductible
Mental health outpatient coverage No limits	80% coverage after deductible	70% coverage after deductible
Alcohol/drug abuse services		
Substance abuse inpatient coverage No limits	80% coverage after deductible	70% coverage after deductible
Substance abuse outpatient coverage No limits	80% coverage after deductible	70% coverage after deductible
Other professional care		
Physical/occupational/speech therapy No limits	• 80% coverage after deductible	• 70% coverage after deductible
Spinal manipulation No limits	• 80% coverage after deductible	• 70% coverage after deductible
Acupuncture Must be administered by a medical doctor or a licensed acupuncturist for pain management	• 80% coverage after deductible	• 70% coverage after deductible
Skilled nursing facility 120 days per calendar year	• 80% coverage after deductible	• 70% coverage after deductible
Hospice Care facility 30 day lifetime maximum inpatient/$5,000 lifetime maximum outpatient	• 80% coverage after deductible	• 70% coverage after deductible
Home Health Care 120 visits per calendar year	• 80% coverage after deductible	• 70% coverage after deductible
Private Duty Nursing 70 visits per calendar year	• 80% coverage after deductible	• 70% coverage after deductible
Infertility services Limited to the testing and treatment of underlying condition	• 80% coverage after deductible up to maximum	• 70% coverage after deductible up to maximum

Type of Service	Outside the U.S. and Preferred Benefits (in-network coverage in the U.S.)	Non-preferred Benefits (out-of-network coverage in the U.S.)
Prescription drug coverage		
• Generic drugs (365 day maximum supply) • Formulary Brand Name drugs (365 day maximum supply)	**Outside the U.S.**: 80% coverage after deductible **In-Network in the U.S.**: 80% per one month supply (includes Mail Order Drugs)	70% coverage after deductible

Wellness Services

Charges for routine care exams are based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams including well-woman and well-child exams and immunizations.

Preventive care services are included in this plan. Both exams and immunizations are covered by in-network providers in the U.S. and out-of-network providers outside the U.S. at 100% with no deductible to meet.

Preventive care services include but are not limited to:

- Routine physical exams and diagnostic tests, for example, complete blood count (CBC), cholesterol blood test and urinalysis and immunizations;
- Well-child services and routine pediatric care and immunizations for children; and
- Routine well-woman exams;.

In addition to well-woman exams, the following women's preventive services are covered by in-network providers at 100% with no deductible to meet:

- Well-woman office visit to obtain recommended preventive services that are developmentally appropriate, including preconception and prenatal care;
- Food and Drug Administration (FDA)-approved contraceptive methods, sterilization procedures and patient education and counseling for women with reproductive capacity (excluding drugs that induce abortion);
- Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period (including costs for renting breast pumps and nursing-related supplies);
- Human papillomavirus virus (HPV) DNA testing as part of cervical cancer screenings for women age 30 and older; and
- Screening for gestational diabetes.

Additional preventive care services covered in full by Citi medical plans, as part of the Affordable Care Act (also referred to as PPACA) include:

- Preventive services related to pregnancy for dependent children;
- Anesthesia performed in connection with a preventive colonoscopy;
- Genetic counseling and BRCA genetic testing for women who have had non BRCA-related breast or ovarian cancer;
- Gender-based preventive services for transgender individuals;

- Human immune-deficiency virus (HIV) counseling and screening for all sexually active people;
- Interpersonal and domestic violence screening and counseling;
- Counseling on sexually transmitted infections for all sexually active people;
- Tobacco-use cessation (for non-pregnant adults): counseling, behavioral interventions and US Food and Drug Administration (FDA)-approved pharmacotherapy;
- Tobacco-use cessation (for pregnant women): counseling and behavioral interventions;
- Diabetes screening (at-risk adults): screening for abnormal blood glucose as part of cardiovascular risk assessment for overweight or obese adults ages 40–70 years; and intensive behavioral counseling about diet and exercise for patients with abnormal blood glucose;
- High blood pressure screening (adults): hypertension screening for adults ages 18 and older;
- Obesity Preventive Counseling; and
- Alcohol/Drug Abuse Preventive Counseling.

Contact your plan for details.

vHealth Virtual Care

Your Citi Expatriate Medical plan includes vHealth (Worldwide) -- a virtual health service that brings doctors to you without the need to visit an office. With vHealth, you have access to doctors 24 hours a day via video or telephone.

Some highlights of vHealth include:

- vHealth is free
- You can use it as often as you need
- Signing up is quick and easy

vHealth is completely confidential and doctors are specially trained to conduct remote consultations and provide the guidance and support you need, whether it's a diagnosis, help managing a chronic condition or getting a prescription.

Register today!

Be sure to register, so you have access when you need it:

- Visit vhealth-teladochealth.com or download 'vHealth (Worldwide)' from Google Play or the App Store
- Follow the registration instructions to open an account
- Use access code Aetna267 during registration

If you have any problems accessing the service, please contact the vHealth support team:

- Email: vHealth@teledochealth.com
- Tel UK: +44 (0) 20 3499 2851
- Tel USA: +1 (0) 8572 563 784

Be sure to save 'vHealth (Worldwide)' contact information in your phone to quickly and easily book appointments in the future. Please note: as prescription regulation varies country to country, vHealth cannot guarantee prescriptions.

Virtual Care within the United States

vHealth is available only to plan members outside of the United States. Only those members with current addresses outside the US will be invited to register. If a registered member travels to the US, they will not be able to consult with a vHealth doctor during their stay. However, while in the US, covered plan members can access virtual care through Teladoc. With Teladoc, you can talk with a doctor within an hour by phone or app from wherever you are inside the United States. For more information visit , visit www.teladoc.com or call 1 (855) TELADOC (835-2362).

Gender Affirmation Benefits

For gender affirmation treatment benefits for members with gender dysphoria, the criteria that are used for determining the medical necessity of services for the diagnosis and treatment are based on the 7th edition of the clinical guidelines set forth by the World Professional Association for Transgender Health (WPATH) in their Standards of Care document. However, not all of the services included in WPATH are covered. Please see below for those services that are generally covered and those services that are not covered

Many of the services noted below require pre-service authorization. Contact the Plan's Member Services for details.

It is strongly recommended that you call the applicable claims administrator before receiving any related services to ensure that the services you seek are covered under the Plan.

Generally, covered expenses include:

- Outpatient office visits
- Hormone therapy (and any subsequent associated risks) is covered under the pharmacy benefit (refer to the Prescription Drugs section for coverage information and any pre-service authorization instructions)
- Puberty suppression
- Voice modification and communication therapy
- Genital surgery and surgery to change secondary sex characteristics (including but not limited to thyroid chondroplasty, bilateral mastectomy, and augmentation mammoplasty) when the treatment plan conforms to the most recent edition of the World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. Inpatient hospital services or treatment require pre-service authorization
- Reconstructive and complementary procedures (including but not limited to tracheal shave, male chest reconstruction, pectoral implants, gluteal augmentation, hair removal and hair transplants) according to the most recent edition of the World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People. The Plan will review appropriateness of treatment. Inpatient hospital services or treatment require pre-service authorization.
- All preventive care is covered regardless of sex assigned at birth.

Note that all covered expenses are subject to plan pre-authorization limits and WPATH eligibility criteria.

Not covered

- Services performed solely for beautification or to improve appearance;
- Charges for services or supplies that are not based on the guidelines set forth by the WPATH.
- Donor sperm and eggs

If a member has followed all of the criteria and clinical guidelines outlined in the WPATH Standards of Care, the plan will not cover costs related to reversal procedures or services. However, complications of procedures derived from reversal surgeries or treatments that are medically necessary will be covered.

Maternity Benefits

Group health plans and health insurance issuers generally may not, under U.S. federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, U.S. federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under U.S. federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours/96 hours. The above does not apply to births that take place outside the U.S.; contact the Aetna International Service Center for more information.

Reminders about Coverage for Newborns

Aetna International specializes in Expatriate benefits. Aetna International's customer service representatives are available 24/7. AT&T's language line is available so you or your spouse/partner can use any language to speak with an Aetna International representative. To cover a newborn under your Citi medical/dental coverage, you must notify Citi within 31 days of the child's birth. See "How to report a qualified change in status event." While you may want to call Aetna International directly to report the birth of a child, your child will not be covered unless you call the Citi Benefits Center within 31 days. Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600 (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +1 (800) 881-3938 (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

You also can visit YBR™ through My Total Compensation and Benefits at **www.totalcomponline.com**

- Expatriates can log on using their User ID and Single Sign-on.

Covered Expenses and Exclusions

Covered expenses are defined as medical and related costs incurred by participants that qualify for reimbursement under the terms of the plan or insurance contract. Please see "Covered Expenses and Exclusions" listed in the section for active Expat employees.

The expenses listed are examples of expenses not covered. Call Aetna International toll free at **+1 (800) 231-7729** or **+1 (813) 775-0190** (collect calls accepted) for information about additional services or supplies that are not covered.

How the Plan Works

Deductible

For out-of-network coverage in the U.S., a deductible applies. The deductible is the amount of covered expenses that must be paid by you before the plan pays any benefit. Once you meet your annual deductible, the Plan will pay a percentage of maximum allowed amounts (MAA), subject to plan limits, for your remaining covered expenses in that plan year. After you meet your annual deductible, the Plan will pay 100% of covered charges.

There are two types of deductibles: Individual and family.

Individual	The amount each person must pay before benefits will be paid. **Note:** If the family deductible has been met, the individual deductible does not apply to the individual.
Family	The amount the family as a whole must pay before benefits will be paid.

A deductible does not apply to coverage outside of the U.S. The benefit level outside the U.S. will be the same as for "in-network coverage" in the U.S.

Out-of-Pocket Maximums for Medical and Prescription Drug Coverage

The medical out-of-pocket maximum limits the amount you will pay in a plan year if you or your family incurs large medical bills. The medical out-of-pocket maximum is the maximum amount of covered medical expenses you would have to pay out of your own pocket before most plan benefits will be payable at 100% of maximum allowed amounts (MAA).

Once the maximum out-of-pocket amount has been met, the plan will pay 100% of the MAA for covered medical costs for the remainder of the year. However, if the expenses incurred are higher than the MAA, the individual receiving the service is responsible for paying the difference between the MAA and the provider's charges even if the out-of-pocket maximum has been reached.

Individual	The amount each member must pay at the coinsurance rate before most of his/her benefits are paid at 100%. **Note:** If the family out-of-pocket maximum has been met, the individual out-of-pocket does not apply to the individual.
Family	The amount all covered members as a whole will pay at the coinsurance rate before most benefits are paid at 100%.

Medical Necessity

To be covered by the Citi Expatriate Medical Plan, a service or supply must be considered medically necessary. A service or supply qualifies as *medically necessary* if it is a generally accepted health care practice and is required to treat your condition, as determined by Aetna International. This means it is deemed to be:

- Widely accepted among health care professionals as effective, appropriate and essential;
- Based on the recognized standards of the health care specialty involved;
- Not provided solely for personal comfort or convenience;
- The most cost-effective level of care that can be safely and adequately provided (for example, medically necessary inpatient care includes services that could not safely and adequately be provided through outpatient services);
- Provided, prescribed or approved by a legally licensed doctor of medicine practicing within the scope of his or her license; and
- Provided while you are covered under the Plan.

Aetna International, Citi's claims administrator for the Citi Expatriate Medical Plan, determines medical necessity.

Maximum Allowed Amount (MAA)

The MAA is any charge that, for services rendered by or on behalf of an out-of-network physician, does not exceed the amount determined by Aetna International in accordance with the applicable fee schedule.

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

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

Referrals to Medical Providers

Aetna International representatives can refer you and your covered family members to medical professionals in most countries. Additionally, local quality monitoring and case management will be available to help you and your covered family members manage an illness.

If you are assigned to work in the U.S. or you have covered treatment in the U.S., Citi encourages you to use an in-network provider in the Aetna network. If you do, you will have fewer out-of-pocket expenses for your medical care than if you use an out-of-network provider.

You do not need to select any doctor in advance. You can visit any doctor within the Aetna network to get the higher level of reimbursement.

You can find an extensive directory of both international and U.S. doctors in the Aetna International network by:

- Visiting Aetna International website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the number listed at the back of this book.

If you are assigned to work outside the U.S. please refer to the “Choosing an Aetna in-network provider outside the U.S.”

Prescription Drugs

The Citi Expatriate Medical Plan includes coverage for prescription medicines. Additionally, when you and your eligible family members are in the U.S. or its territories, you may access the Aetna Pharmacy Management network of more than 59,000 participating pharmacies to save money on prescriptions from doctors, dentists or hospitals/clinics.

You can use the Aetna International online directory to search U.S. destinations to find a participating pharmacy. Simply present your Aetna International ID card and prescription to the in-network pharmacist and he or she will collect your copayment and bill Aetna International for the balance due. If you fill your prescription at a non-participating pharmacy in the U.S., you must pay the entire cost and submit a claim for reimbursement under the non-preferred benefits of the plan.

Remember, the advantage of the Aetna Pharmacy Management program applies to those using participating pharmacies in the U.S. or its territories only. As an Aetna International member under the Citi Expatriate Medical Plan, you may go to any pharmacy anywhere in the world. However, you will need to pay for your prescription drug and then submit a claim form to Aetna International for medications obtained from non-participating pharmacies, which includes pharmacies outside the U.S.

Aetna Rx Home Delivery is Aetna’s mail-order prescription drug service that ships maintenance medications to U.S. addresses only. U.S. federal law does not permit the mailing of prescription drugs outside the U.S. If you are a U.S. resident, you can receive prescriptions through the mail when you are on a home visit or temporarily residing in the U.S. U.S. residents are also eligible to fill three-, six-, nine- and 12-month prescriptions (based on your doctor’s orders) at pharmacies throughout the U.S. that participate in Aetna’s network.

For specialty and/or emergency medications unavailable in your country of assignment, please contact the CARE Team via Aetna International Member Services and ask to speak to a CARE Team nurse.

The CARE Team can also assist you with:

- Pre-trip planning specific to your assignment country;
- Coordinating routine and urgent medical care worldwide during your assignment;
- Locating providers and disease management specialists and in obtaining medical devices or prescription medications; and
- Coordinating and supervising medical evacuations and other emergency assistance.

Direct Settlement

As an Aetna International member, you are free to go to any hospital you choose, but some hospitals require payment at the time of service. For potentially high-cost procedures, it is most convenient to establish a direct-pay relationship with the hospital. This can be done online, or in an emergency, you or the provider can call the number on the back of your ID card at any time, day or night. Aetna International representatives are available 24/7 and they can assist in establishing a direct-pay arrangement.

When you access care at an Aetna International-contracted, direct-pay medical facility or provider, your out-of-pocket expenses may be reduced because, generally, you will be responsible for a smaller portion of the bill and Aetna International will pay the facility directly for any remaining covered expenses according to your specific benefits coverage.

If you do not find the facility that you are looking for in Aetna International's direct-pay database, you can request that Aetna International coordinate a one-time direct payment arrangement with that facility. If Aetna International is able to arrange for payment, it will evaluate the opportunity to add that facility to its list of regular direct-pay providers.

Claiming Expenses

You must file a claim to be reimbursed for your medical and dental expenses. In the U.S., medical providers in the Aetna International network often will file the claim for you. You can obtain claim forms:

- By copying the forms you receive from Aetna International after you enroll;
- By printing the forms from the Expatriate Program Support page of the *Citi For You* website;
- By printing the forms from the Aetna International website at www.aetnainternational.com; and
- By calling Aetna International to request a form; see the telephone number at the back of this book.

For medical and dental expenses incurred out of network in the U.S. and outside the U.S. you will be required to pay for the expense and submit a claim form to Aetna International for reimbursement. Aetna International accepts claims in any language without translation or currency conversion. When charges for expenses are converted to U.S. dollars, Aetna International will use the exchange rate on the date the expense was incurred.

Be Sure to File Claims Promptly!

The Citi Expatriate Medical Plan and Expatriate Dental Plan will not pay claims filed more than 12 months after the charges were incurred, unless the charges relate to a claim already on file.

Payment of Claims

When paying claims, Aetna International can:

- Electronically deposit your reimbursements for the cost of medical and dental care into your U.S. bank account; or
- Reimburse you, or pay the provider directly, in local currency.

You can indicate your preference for method of claims reimbursement on the claim form. Claims submitted are usually processed within 16 business days after receipt of the completed claim form.

Tips to Speed Claim Processing

- Be sure to fill out the claim form completely; an incomplete form may delay processing.
- Provide a diagnosis or explanation of treatment on the claim form.
- Be certain that all receipts are legible. Receipts must be fully itemized bills and/or detailed receipts that include diagnosis (nature of illness) and the procedures or services performed.
- Write your member identification number on each document submitted with your claim form (this number is located on your Aetna ID card).
- Be sure to indicate the name of the person who received care (either yourself or your dependent).
- Include contact information (phone, fax or email) where you can be reached in case Aetna International has any questions about your claim.
- State how and where you want the reimbursement issued.
- Fax or send an email with your form instead of mailing it.
- Save copies of your bills, receipts and claim forms.

You can submit your claim in any of four ways:

Mail	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543USA
Overnight delivery	Aetna International 4630 Woodland Corporate Blvd. Tampa, FL 33614 USA
Fax	For faster turnaround of claim payment, fax your claim form and supporting documentation to: Direct: **+1 (813) 775-0625** Toll free: **+1 (800) 475-8751**
Email	AiService@aetna.com
Member Portal	The fastest way for members to be reimbursed without having to fill out a paper claim form is through the member portal at **www.aetnainternational.com**.

Aetna International can reimburse your covered medical and dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT) or wire the money directly to your bank account. Aetna International will cover any applicable fees.

To select your method of reimbursement and preferred currency, complete the “Summary of Reimbursement” and, as applicable, “Banking” section(s) of the claim form. The choice of reimbursement is up to you.

Alternatively, if you prefer to be reimbursed the same way each time, you can advise Aetna International in one of the following ways:

By mail	Complete a Recurring Reimbursement Request form available at www.aetnainternational.com and either send it with your next claim or on its own.
Online	Visit the Aetna International member website at www.aetnainternational.com. • Click on the "Resources" tab at the top of the page. • Click "Forms." • Select "Online RRE Enrollment" under "Recurring Reimbursement Election (RRE)." • Complete the online form and send to Aetna International.

For more information about the currencies and payment methods in which Aetna International can provide claim reimbursement, visit www.aetnainternational.com or call the Aetna International Service Center using the telephone number on your member ID card or at the back of this book.

Claims and Appeals

When a claim comes in, you will receive a decision on how you and the Plan will split the expense. Aetna International will also explain what you can do if you disagree with a claims decision.

Claims are processed in the order in which they are received.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Claim Procedures

For claims involving out-of-network providers:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the Aetna International Service Center. • The claim form will provide instructions on how to complete and where to send the form(s).	• Within 15 working days of your request. • If the claim form is not sent on time, we will accept a written description that is the basis of the claim as proof of loss. It must detail the nature and extent of loss within 90 days of your loss.

Notice	Requirement	Deadline
Proof of loss (claim)	• A completed claim form and any additional information required by the Plan.	• No later than 90 days after you have incurred expenses for covered benefits. • Aetna International won't void or reduce your claim if you can't send us notice and proof of loss within the required time. But you must send them notice and proof as soon as reasonably possible. • Proof of loss may not be given later than two years after the time proof is otherwise required, except if you are legally unable to notify Aetna International.
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by Aetna International, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Types of Claims and Communicating Claim Decisions

You or your provider are required to send Aetna International a claim in writing. Aetna International will review that claim for payment to the provider.

There are different types of claims. The amount of time allowed to tell you about a decision on a claim depends on the type of claim. The section below will tell you about the different types of claims.

Urgent Care Claim
An urgent claim is one for which delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. Or it could be a situation in which you need care to avoid severe pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-Service Claim
A pre-service claim is a claim that involves services you have not yet received and which the Plan will pay for only if Aetna International pre-certifies them.

Post-Service Claim
A post service claim is a claim that involves health care services you have already received.

Concurrent Care Claim Extension
A concurrent care claim extension occurs when you ask Aetna International to approve more services than they already have approved. Examples are extending a hospital stay or adding a number of visits to a provider.

Concurrent Care Claim Reduction or Termination

A concurrent care claim reduction or termination occurs when Aetna International decides to reduce or stop payment for an already approved course of treatment. The Plan will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from Aetna International or an external review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If Aetna International upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

The chart below shows a timetable view of the different types of claims and how much time the Claims Administrator has to tell you about the decision.

Aetna International may need to tell your physician about their decision on some types of claims, such as a concurrent care claim, or a claim when you are already receiving the health care services or are in the hospital.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Initial determination (Aetna International)	72 hours	15 days	30 days	24 hours for urgent request* 15 calendar days for non-urgent request
Extensions	None	15 days	15 days	Not applicable
Additional information request (Aetna International)	72 hours	15 days	30 days	Not applicable
Response to additional information request (you)	48 hours	45 days	45 days	Not applicable

*Aetna International has to receive the request at least 24 hours before the previously approved health care services end.

Adverse Benefit Determinations

The Plan may pay many claims at the full rate negotiated charge with a network provider and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes the Plan will pay only some of the claim. And sometimes they may deny payment entirely. Any time the Plan denies even part of the claim that is an "adverse benefit determination" or "adverse decision". It is also an "adverse benefit determination" if Aetna International rescinds your coverage entirely.

If the Plan makes an adverse benefit determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can call or write to Aetna International Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna International will review the information and provide you with a written response within 30 calendar days of receiving the complaint. They will let you know if more information is needed to make a decision.

An Appeal

You can ask Aetna International to re-review an adverse benefit determination. This is called an appeal. You can make an appeal verbally or in writing.

Appeals of Adverse Benefit Determinations

You can appeal an adverse benefit determination. Aetna International will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Aetna International Member Services at the address on the notice of adverse benefit determination. Or you can call Aetna International Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like to be considered

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell the Plan if you choose to have someone else appeal for you (even if it is your provider). You should fill out an authorized representative form telling Aetna International that you are allowing someone to appeal for you. You can get this form by contacting Aetna International Member Services. You can use an authorized representative at any level of appeal.

You can appeal two times under this Plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Urgent Care or Pre-Service Claim Appeals

If your claim is an urgent claim or a pre-service claim, your provider may appeal for you (without having you fill out an authorized representative form).

Aetna International will provide you with any new or additional information that was used or that was developed to review your claim. Aetna International will provide this information at no cost to you before giving you a decision at your last available level of appeal. This decision is called the final adverse benefit determination. You can respond to this information before the Plan tells you what their final decision is.

Timeframes for Deciding Appeals

The amount of time that the Plan has to tell you about decisions on an appeal claim depends on the type of claim as outlined below.

Type of notice	Urgent care claim	Pre-service claim	Post-service claim	Concurrent care claim
Appeal determinations at each level (Aetna International)	36 hours	15 days	30 days	As appropriate to type of claim
Extensions	None	None	None	

Exhaustion of the Appeals Process

In most situations you must complete the two levels of appeal with Aetna International before you can take these other actions:

- Appeal through an external review process.
- Pursue arbitration, litigation or other type of administrative proceeding.

But sometimes you do not have to complete the two levels of appeals process before you may take other actions. These situations are:

- You have an urgent claim or a claim that involves ongoing treatment. You can have your claim reviewed internally and at the same time through the external review process.
- Aetna International did not follow all of the claim determination and appeal requirements of the Federal Department of Health and Human Services. But, you will not be able to proceed directly to external review if:
  - The rule violation was minor and not likely to influence a decision or harm you.
  - The violation was for a good cause or beyond our control.
  - The violation was part of an ongoing, good faith exchange between you and Aetna International.

External review

External review is a review done by people in an organization outside of Aetna. This is called an external review organization (ERO).

You have a right to external review only if:

- Your claim decision involved medical judgment.
- Aetna decided the service or supply is not medically necessary or not appropriate.
- Aetna decided the service or supply is experimental or investigational.
- You have received an adverse determination.

If the claim decision is one for which you can seek external review, Aetna will say that in the notice of adverse benefit determination or final adverse benefit determination they send you. That notice also will describe the external review process. It will include a copy of the Request for External Review form at the final adverse determination level.

You must submit the Request for External Review Form:

- To Aetna
- Within 120 calendar days (four months) of the date you received the decision
- And you must include a copy of the notice from us and all other important information that supports your request

You will pay for any information that you send and want reviewed by the ERO. Aetna International will pay for information they send to the ERO plus the cost of the review.

Aetna will:

- Contact the ERO that will conduct the review of yourclaim.
- Assign the appeal to one or more independent clinical reviewers that have the proper expertise to do the review.
- Consider appropriate credible information that yousent.
- Follow contractual documents and your plan ofbenefits.
- Send notification of the decision within 45 calendar days of the date your request form is received and all the necessaryinformation.

Aetna International will stand by the decision that the ERO makes, unless they can show conflict of interest, bias or fraud. They will tell you of the ERO decision not more than 45 calendar days after receipt of your Notice of External Review Form with all the information you need to send in. But sometimes you can get a faster external review decision. Your provider must call or send Aetna International a Request for External Review Form.

There are two scenarios when you may be able to get a faster external review:

For initial adverse determinations

Your provider states that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function, or
- Be much less effective if not started right away (in the case of experimental or investigational treatment)

For final adverse determinations

Your provider tells us that a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function;
- Be much less effective if not started right away (in the case of experimental or investigational treatment), or
- The final adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility.

If your situation qualifies for this faster review, you will receive a decision within 72 hours of us getting your request.

Recordkeeping

Aetna International will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

Aetna International does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Dental Coverage

The Citi Retiree Expatriate Dental Plan was designed to encourage preventive care and to help pay the cost when you need dental treatment. You can visit any dentist anywhere in the world and receive coverage as described in this section.

The plan pays benefits up to maximum allowed amounts. Coverage limits apply.

Aetna Dental PPO Network

If you or a covered dependent needs dental care in the U.S., you can take advantage of the Aetna Dental PPO Network.

You are not required to select an Aetna Dental Network provider. However, if you choose to go to an Aetna Dental Network provider you can take advantage of discounts available in most states.

You can also find a directory of dentists in the Aetna Dental Network by:

- Visiting the Aetna International website at www.aetnainternational.com; or
- Calling the Aetna International Service Center at the telephone numbers at the back of this book.

Expatriate Retiree Dental Plan Coverage at-a-Glance

Annual individual deductible	US($) 75 per calendar year
Annual family deductible	US($) 225 per calendar year
Maximum annual benefit (per person)	US($) 2,000 per calendar year
Diagnostic and preventive services • Routine oral exams • Routine cleanings • Fluoride treatments • Sealants • X-rays	100% coverage; not subject to deductible • Up to two exams per calendar year • Up to two cleanings per calendar year • One fluoride application per calendar year, up to age 16 • Sealants up to age 19; age 14 and under (permanent molars only) • One full-mouth series X-ray per 36 months and up to two bitewing X-rays per year
Basic restorative • Fillings; amalgam (“silver”) and composite (“white”) • Extractions • Endodontic treatment • Oral surgery • Repair or re-cementing of crowns, inlays, onlays, bridgework or dentures • Periodontal treatment • General anesthesia (when medically necessary) • Emergency exams • Specialist’s exams • Palliative treatment (emergency only) and related X-rays	80% coverage after deductible
Major restorative • Inlays, onlays, crowns and gold fillings • Removable dentures • Fixed bridgework • Implants	50% coverage after deductible

Deductible

For all covered dental services, except diagnostic and preventive services, each covered person will pay an initial amount each calendar year, called the *deductible,* before the plan will pay benefits. Once you meet your annual deductible, the plan will pay a percentage of maximum allowed amounts, subject to plan limits, for your remaining covered expenses in that year.

Charges applied to the deductible in the last quarter of the year will carry over and be applied to the following year's deductible.

If you enroll for dependent coverage, the plan will limit the combined amount you and your covered dependents must pay in deductibles each calendar year. The limit is three times the individual deductible amount. Your family will not have to pay more in deductibles for the year than the family limit, whether you or any dependent reaches the individual deductible.

Alternative Treatment

Often there is more than one acceptable way to treat a particular dental condition. For example, a partial denture may be a professionally acceptable alternative to a fixed bridge.

When alternate services or supplies can be used, the plan's coverage will be limited to the cost of the least expensive service or supply that is:

- Customarily used nationwide for treatment, and
- Deemed by the dental profession to be appropriate for treatment of the condition in question. The service or supply must meet broadly accepted standards of dental practice, taking into account your current oral condition.

You should review the differences in the cost of alternate treatment with your dental provider. Of course, you and your dental provider can still choose the more costly treatment method. You are responsible for any charges in excess of what the plan will cover.

By obtaining an advance claim review as described below, you can determine in advance if Aetna International will pay benefits based on an alternative method of treatment.

Advance Claim Review

The purpose of the advance claim review is to determine, in advance, the benefits the plan will pay for proposed services. Knowing ahead of time which services are covered by the plan, and the benefit amount payable, helps you and your dentist make informed decisions about the care you are considering.

Important Note: The pre-treatment review process is not a guarantee of benefit payment, but rather an estimate of the amount or scope of benefits to be paid.

When to Get an Advance Claim Review

An advance claim review is recommended whenever a course of dental treatment is likely to cost more than $350. Ask your dentist to write down a full description of the treatment you need, using either an Aetna claim form or an ADA approved claim form. Then, before actually treating you, your dentist should send the form to Aetna. Aetna may request supporting X-rays and other diagnostic records. Once all of the information has been gathered, Aetna will review the proposed treatment plan and provide you and your dentist with a statement outlining the benefits payable by the plan. You and your dentist can then decide how to proceed.

The advance claim review is voluntary. It is a service that provides you with information that you and your dentist can consider when deciding on a course of treatment. It is not necessary for emergency treatment or routine care such as cleaning teeth or check-ups. In determining the amount of benefits payable, Aetna will take into account alternate procedures, services, or courses of treatment for the dental condition in question in order to accomplish the anticipated result.

Dental Services Covered under the Citi Retiree Expatriate Medical Plan

The Citi Retiree Expatriate Medical Plan covers certain treatment of the mouth, teeth, jaw, jaw joints or supporting tissues, including certain major dental work needed after an accidental injury affecting sound, healthy teeth. Call Aetna International, at the telephone number at the back of this book, if you have questions about whether a service is covered under the medical plan or the dental plan.

Dental Rules and Limitations

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

- Reimbursement policies: We have the right to apply Aetna reimbursement policies. Those policies may reduce the negotiated charge or recognized charge. These policies take into account factors such as:
  - The duration and complexity of a service
  - When multiple procedures are billed at the same time, whether additional overhead is required
  - Whether an assistant surgeon is necessary for the service
  - If follow up care is included
  - Whether other characteristics modify or make a particular service unique
  - When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided and
  - The educational level, licensure or length of training of the provider
- Aetna reimbursement policies are based on our review of:
  - The Centers for Medicare and Medicaid Services' (CMS) National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
  - Generally accepted standards of dental practice and
  - The views of providers and dentists practicing in the relevant clinical areas
  - We use commercial software to administer some of these policies. Some policies are different for professional services than for facility services.

Replacement rule: Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Implants
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

- These **eligible dental services** are covered only when you give us proof that:
  - While you were covered by the plan: You had a tooth (or teeth) extracted after the existing denture or bridge was installed. As a result, you need to replace or add teeth to your denture or bridge.
  - The present item cannot be made serviceable, and is:
    - A crown installed at least 5 years before its replacement.
    - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), implant, or other prosthetic item installed at least 5 years before its replacement.
  - While you were covered by the plan:
    - You had a tooth (or teeth) extracted.
    - Your present denture is an immediate temporary one that replaces that tooth (or teeth).
    - A permanent denture is needed, and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.

Dental Expenses Not Covered

The Citi Expatriate Retiree Dental Plan does not cover certain dental expenses. If you have any question about whether a service that is not listed here is covered, call Aetna International. Here are examples of expenses that are *not* covered: Call Aetna International, at the telephone number at the back of this book, if you have questions about whether a service is covered under the medical or the dental plans

These dental exclusions are in addition to the exclusions that apply to health coverage.

- Orthodontia services;
- Any instruction for diet, plaque control and oral hygiene;
- A crown, bridge or gold restoration for which the tooth was prepared before the patient was covered;
- Charges in connection with a work-related injury or illness covered by any Workers' Compensation or any similar law;
- Procedures, appliances or restorations if the main purpose is to: (1) change vertical dimension (degree of separation of the jaw when teeth are in contact) or (2) diagnose or treat abnormal conditions of the temporomandibular joint, except as specifically listed as covered;
- Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect;
- Services considered to be unnecessary or experimental in nature;
- Services provided or paid by or through a governmental agency or authority, political subdivision or public program; and
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided under the Plan. Facings on molar crowns and pontics will always be considered cosmetic.
- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

- Court-ordered services and supplies: Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding.
- Dental services and supplies
  - Acupuncture, acupressure and acupuncture therapy
  - Asynchronous dental treatment
  - Crown, inlays and onlays, and veneers unless for one of the following:
    - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
    - The tooth is an abutment to a covered partial denture or fixed bridge
  - Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
  - Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
  - First installation of a denture or fixed bridge, and any inlay and crown that serves as an abutment to replace congenitally missing teeth or to replace teeth, all of which were lost while you were not covered
  - General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
  - Instruction for diet, tobacco counseling and oral hygiene
  - Mail order and at-home kits for orthodontic treatment
  - **Orthodontic treatment** except as covered in the *Eligible Dental Services* section of the schedule of benefits
  - Dental services and supplies made with high noble metals (gold or titanium) except as covered in the *Eligible Dental Services* section of the schedule of benefits
  - Services and supplies provided in connection with treatment or care that is not covered under the plan
  - Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
  - Replacement of teeth beyond the normal complement of 32
  - Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
  - Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
  - Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons
  - Temporomandibular joint dysfunction/disorder

Dental services and supplies that are covered in whole or in part:

- Under any other part of this plan
- Under any other plan of group benefits provided by the Customer

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.

- Because a court order requires it.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Claiming Expenses

You must file a claim to be reimbursed for your medical and dental expenses. In the U.S., medical providers in the Aetna International network often will file the claim for you. You can obtain claim forms:

- By copying the forms you receive from Aetna International after you enroll;
- By printing the forms from the Expatriate Program Support page of the *Citi For You* website;
- By printing the forms from the Aetna International website at www.aetnainternational.com; and
- By calling Aetna International to request a form; see the telephone number at the back of this book.

For medical and dental expenses incurred out of network in the U.S. and outside the U.S. you will be required to pay for the expense and submit a claim form to Aetna International for reimbursement. Aetna International accepts claims in any language without translation or currency conversion. When charges for expenses are converted to U.S. dollars, Aetna International will use the exchange rate on the date the expense was incurred.

Be Sure to File Claims Promptly!

The Citi Expatriate Medical Plan and Expatriate Dental Plan will not pay claims filed more than 12 months after the charges were incurred, unless the charges relate to a claim already on file.

Payment of Claims

When paying claims, Aetna International can:

- Electronically deposit your reimbursements for the cost of medical and dental care into your U.S. bank account; or
- Reimburse you, or pay the provider directly, in local currency.

You can indicate your preference for method of claims reimbursement on the claim form. Claims submitted are usually processed within 16 business days after receipt of the completed claim form.

Tips to Speed Claim Processing

- Be sure to fill out the claim form completely; an incomplete form may delay processing.
- Provide a diagnosis or explanation of treatment on the claim form.
- Be certain that all receipts are legible. Receipts must be fully itemized bills and/or detailed receipts that include diagnosis (nature of illness) and the procedures or services performed.
- Write your member identification number on each document submitted with your claim form (this number is located on your Aetna ID card).
- Be sure to indicate the name of the person who received care (either you or your dependent).

- Include contact information (phone, fax or email) where you can be reached in case Aetna International has any questions about your claim.
- State how and where you want the reimbursement issued.
- Fax or send an email with your form instead of mailing it.
- Save copies of your bills, receipts and claim forms.

You can submit your claim in any of four ways:

Mail	Aetna International/Aetna P.O. Box 981543 El Paso, TX 79998-1543USA
Overnight delivery	Aetna International 4630 Woodland Corporate Blvd. Tampa, FL 33614 USA
Fax	For faster turnaround of claim payment, fax your claim form and supporting documentation to: Direct: **+1 (813) 775-0625** Toll free: **+1 (800) 475-8751**
Email	AiService@aetna.com

Aetna International can reimburse your covered medical and dental expenses in more than 180 currencies via check or Electronic Funds Transfer (EFT) or wire the money directly to your bank account. Aetna International will cover any applicable fees.

To select your method of reimbursement and preferred currency, complete the "Summary of Reimbursement" and, as applicable, "Banking" section(s) of the claim form. The choice of reimbursement is up to you.

Alternatively, if you prefer to be reimbursed the same way each time, you can advise Aetna International in one of the following ways:

By mail	Complete a Recurring Reimbursement Request form available at www.aetnainternational.com and either send it with your next claim or on its own.
Online	Visit the Aetna International member website at www.aetnainternational.com. • Click on the "Resources" tab at the top of the page. • Click "Forms." • Select "Online RRE Enrollment" under "Recurring Reimbursement Election (RRE)." • Complete the online form and send to Aetna International.

For more information about the currencies and payment methods in which Aetna International can provide claim reimbursement, visit www.aetnainternational.com or call the Aetna International Service Center using the telephone number on your member ID card or at the back of this book.

Claims and Appeals

When a claim comes in, you will receive a decision on how you and the Plan will split the expense. Aetna International will also explain what you can do if you disagree with a claims decision.

Claims are processed in the order in which they are received.

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact your medical plan Claims Administrator to obtain a claims appeal form. For claims regarding eligibility or enrollment in a plan, call the Citi Benefits Center through ConnectOne.

Claim Procedures

You or your dental provider are required to send Aetna International a claim in writing. They will review that claim for payment to the provider or to you as appropriate. The following table explains the claims procedure:

Notice	Requirement	Deadline
Submit a claim	• You should notify and request a claim form from the Aetna International Service Center. • The claim form will provide instructions on how to complete and where to send the form(s).	• You must send Aetna International notice and proof within 90 days • If you are unable to complete a claim form, you may send: • A description of services • Bill of charges • Any dental documentation you received from your dental provider
Proof of loss (claim) **When you have received a service from an eligible dental provider, you will be charged.** **The information you receive for that service is your proof of loss.**	• A completed claim form and any additional information required by the Plan.	• You must send notice and proof within 90 days
Benefit payment	• Written proof must be provided for all benefits. • If any portion of a claim is contested by Aetna International, the uncontested portion of the claim will be paid promptly after the receipt of proof of loss.	• Benefits will be paid as soon as the necessary proof to support the claim is received.

Communicating Claim Decisions

The amount of time allowed to tell you about a decision on a claim is shown below.

Post-Service Claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial determination (Aetna International)	30 days
Extensions	15 days
Additional information request (Aetna International)	30 days
Response to additional information request (you)	45 days

During this continuation period, you are still responsible for your share of the costs, such as copayments/payment percentage and deductibles that apply to the service or supply. If Aetna International upholds their decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Adverse Benefit Determinations

The Plan may pay many claims at the full rate negotiated charge with in-network providers and the recognized amount with an out-of-network provider, except for your share of the costs. But sometimes the Plan will pay only some of the claim. And sometimes they may deny payment entirely. Any time the Plan denies even part of the claim that is an "adverse benefit determination" or "adverse decision."

If the Plan makes an adverse benefit determination, they will tell you in writing.

The Difference between a Complaint and an Appeal

A Complaint

You may not be happy about a dental provider or an operational issue, and you may want to complain. You can call or write to Aetna International Member Services. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. Aetna International will review the information and provide you with a written response within 30 calendar days of receiving the complaint. They will let you know if more information is needed to make a decision.

An Appeal

You can ask Aetna International to re-review an adverse benefit determination. This is called an appeal. You can make an appeal verbally or in writing.

Appeals of Adverse Benefit Determinations

You can appeal an adverse benefit determination. Aetna International will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to Aetna International Member Services at the address on the notice of adverse benefit determination. Or you can call Aetna International Member Services at the number on your ID card. You need to include:

- Your name
- The employer's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like to be considered

Another person may submit an appeal for you, including a provider. That person is called an authorized representative. You need to tell the Plan if you choose to have someone else appeal for you (even if it is your dental provider). You should fill out an authorized representative form telling Aetna International that you are allowing someone to appeal for you. You can get this form by contacting Aetna International Member Services. You can use an authorized representative at any level of appeal.

You can appeal two times under this Plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for Deciding Appeals

The amount of time that the Plan has to tell you about decisions on an appeal claim depends on the type of claim as outlined below.

Type of notice	Post-service claim
Appeal determinations at each level (Aetna International)	30 days
Extensions	None

Exhaustion of Appeals Process

In most situations you must complete the appeal process with Aetna International before you can pursue arbitration, litigation or other type of administrative proceeding.

Recordkeeping

Aetna International will keep the records of all complaints and appeals for at least 10 years.

Fees and Expenses

Aetna International does not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Life and Accident Insurance

Group Universal Life (GUL) Insurance

Your GUL coverage may be continued under an individual policy. MetLife will send you information regarding the continuation of your GUL coverage once notified of your retirement. If you continue your GUL coverage, MetLife will bill you directly at a higher rate than the Citi group insurance rate. The rate will become effective in the month following your termination of employment or transfer. If you have any questions on continuing your coverage, call MetLife directly at +**1 (888) 830-7380**.

Supplemental AD&D Insurance

When you retire from Citi, you and your spouse/partner and children may continue coverage by paying premiums directly to MetLife. If you continue coverage, MetLife will bill you at a higher rate than the Citigroup insurance rate effective the month following the loss of eligibility. If you have any questions on coverage continuation, call MetLife directly at +**1 (888) 252-3607**.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires most employers sponsoring group health plans to offer retirees and their eligible dependents covered under the Plans the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances where coverage under the Plans 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 eligibility for coverage. Citi reserves the right to terminate coverage retroactively if you are determined to be ineligible under the terms of the Expatriate Retiree Health Plans.

You will have to pay the entire premium plus a 2% administrative fee for your continuation coverage. Your first premium must be paid within 60 days of the date you elect COBRA coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled premiums.

Who Is Covered

If you are the spouse or partner of a retiree and are covered by any of the Expatriate Retiree Health Plans 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 any of the Plans for any of the following reasons:

- Divorce or legal separation from the retiree;
- The retiree becomes entitled to Medicare (N/A for retiree outside U.S., if permanent residence in U.S. or Puerto Rico, applicable); or
- The retiree dies.

If you are a covered dependent child of a retiree covered under any of the Expatriate Retiree Health Plans on the day before the qualifying event, you are a qualified beneficiary and have the right to continuation coverage if group health coverage under any of the Plans is lost for any of the following reasons:

- You cease to be a “dependent child” as defined under the Expatriate Retiree Health Plans;
- The retiree becomes entitled to Medicare (N/A for retiree outside U.S., if permanent residence in U.S. or Puerto Rico, applicable); or
- The retiree dies.

Separate Elections

Each qualified beneficiary has an independent election right for COBRA continuation coverage. For example, if there is a choice among types of coverage offered to similarly situated individuals who have not had a qualifying event, each qualified beneficiary who is eligible for continuation coverage is entitled to make a separate election among the types of coverage. However, when the qualifying event first occurs the qualified beneficiary can elect only the coverage in effect immediately before the qualifying event.

COBRA Coverage in the Event of Bankruptcy

If the employer from which you retired should file for bankruptcy under Title 11 of the United States Code and there is a loss or a substantial elimination of retiree medical coverage within one year before or after such bankruptcy filing, you and your eligible dependents are entitled to COBRA continuation coverage.

You and your eligible dependents are entitled to COBRA continuation coverage for your lifetime. After your death, your surviving spouse and dependents are entitled to an additional 36 months of COBRA continuation coverage. If, at the time of the bankruptcy filing, you are deceased but your surviving spouse is covered by the Expatriate Retiree Health Plans (and loses coverage as described above), your surviving spouse is entitled to lifetime COBRA continuation coverage.

Your Duties

Under the law, the retiree or a family member is responsible for informing Citi of a divorce, legal separation or a child's loss of dependent status under the Expatriate Retiree Health Plans. This notice must be provided to Citi within 60 days from the date of the divorce, legal separation or child's loss of dependent status (or, if later, the date coverage would normally be lost because of the event).

If the retiree or a family member fails to provide this notice to Citi within 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:

Citi Benefits Center

P. O. Box 785004

2300 Discovery Drive

Orlando, FL 32878-5004

When Citi is notified that one of these qualifying events has occurred, Citi, in turn, will notify those who have the right to elect COBRA continuation coverage. If you or your family member fails to notify Citi and any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the divorce, legal separation or a child's loss of dependent status, then you and your family members will be required to reimburse the Plans for any claims mistakenly paid.

Citi's Duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the retiree or a family member) if either of the following events occurs that will result in a loss of coverage:

- The retiree becomes entitled to Medicare (N/A for retiree outside U.S., if permanent residence in U.S. or Puerto Rico, applicable); or
- The retiree dies.

Electing COBRA

To elect or inquire about COBRA coverage, call the Citi Benefits Center as instructed on page 2.

Under the law, qualified beneficiaries must elect continuation coverage within 60 days from the date they would lose coverage because of one of the events described earlier, or, if later, 60 days after Citi provides them notice of their right to elect continuation coverage. A qualified beneficiary 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, Citi is required to provide you with coverage that is identical to the coverage provided under the Expatriate Retiree Health Plans to similarly situated retirees or family members. If the coverage for similarly situated individuals is modified, your coverage will be modified. A "similarly situated" individual refers to a current retiree or dependent who has not had a qualifying event.

Duration of COBRA

A qualified beneficiary can elect COBRA continuation coverage for 36 months, unless the qualified beneficiary lost group health coverage because of a bankruptcy filing. Specific qualifying events and the duration of COBRA continuation coverage associated with them are listed below.

Duration of COBRA Coverage			
	Maximum Continuation Period for Each Qualified Beneficiary		
Qualifying Event	Retiree	Spouse/Partner	Child
Death of the Retiree; Retiree and spouse become legally separated or divorced; termination of domestic partnership	Not applicable	36 months	36 months
Child no longer qualifies as a dependent	Not applicable	Not applicable	36 months
Bankruptcy	Lifetime	Retiree's lifetime plus 36 months following the death of the retiree	Retiree's lifetime plus 36 months following the death of the retiree

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

Early Termination of COBRA

The law provides that COBRA continuation coverage may end prior to the expiration of the 36-month or other applicable period for any person who elected COBRA for any of the following reasons:

- Citi no longer offers any group health care coverage;
- The premium for continuation coverage is not paid on time (or 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 pre-existing condition of that covered individual; or
- The person who elected COBRA becomes covered by Medicare after the date COBRA continuation coverage is elected (N/A for retiree outside U.S., if permanent residence in U.S. or Puerto Rico, applicable).

In addition, the Plan Administrator reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the premium for your continuation coverage. The cost of group health coverage periodically changes. If you elect continuation coverage, Citi will notify you of any changes in the cost.

COBRA continuation coverage is not effective until you elect it and make the required payment. The initial payment for continuation coverage is due 60 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 do not make timely payments, your COBRA continuation coverage will be terminated as of the last day of the month for which you made timely payment.

When Coverage Ends

Your coverage under the Citi Retiree Expatriate Health Plans will terminate automatically on the earliest of the following dates:

- The date the Plans are terminated;
- The last day for which the necessary contributions are made; (If your retiree coverage is terminated as result of the failure to pay the applicable premiums, your coverage will cease and cannot be reinstated);
- The day you die;
- To the extent applicable, the date benefits paid on your behalf equal the lifetime maximum benefit under the Plans for such category of benefits; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Retiree Expatriate Health Benefit Plan; in such an event, coverage may be terminated retroactively.

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

- The date you elect to terminate your eligible dependent's coverage;
- The date you become legally separated, divorced, submit a partnership termination form or submit other legal documents showing your termination of the relationship with your partner;
- The last day for which the necessary contributions are made;
- The last date your eligible dependent ceases to be eligible for coverage (coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age);
- The date your eligible dependent is covered as an employee under the Citigroup Health and Insurance Plans;
- The date your eligible dependent enters the armed forces of any country or international organization;
- The date your dependent is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO); The date defined in the dependent verification package if proof of eligibility is not received by the deadline; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Retiree Expatriate Health Benefit Plan; in such an event, coverage may be terminated retroactively.

If You Return to the U.S. and Become Medicare-Eligible

In the event that you change your permanent residence to the U.S. or Puerto Rico after you attain the age of 65 (Medicare-eligible), you will no longer be eligible for benefits under Citi's Retiree Expatriate Health Plans. Medicare-eligible retirees and their Medicare-eligible spouse/partner and eligible dependents who are Medicare-eligible due to attaining age 65 and who meet the eligibility requirements for retiree health coverage are eligible to use the services of Via Benefits, a Willis Towers Watson company, who provides assistance enrolling such retirees and their eligible dependents in appropriate individual Medicare coverage (including medical, prescription drug, dental and vision coverage). To utilize Via Benefits services, you must enroll in Medicare Parts A and B. To avoid late enrollment penalties, you should enroll in Medicare when initially eligible after returning to the U.S. or Puerto Rico.

Administrative and Other Information

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

Coordination of Benefits

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

The Citi Expatriate Medical and Dental Plans and the Citi Expatriate Retiree Medical and Dental Plan (collectively, the “Plans”) contain a coordination-of-benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the other sections of this Benefits Handbook.

The following definitions apply to terms used in this section:

- Allowable expense: Includes any necessary, reasonable and customary expense that would be covered in full or in part under the Plans. 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.
- Plans: Most plans under which group health benefits are provided, including group insurance closed panel or other forms of group or group-type coverage (whether insured or uninsured); medical care components of group long-term care contracts (such as skilled nursing care); medical benefits under group or individual automobile contracts; Workers' Compensation; and Medicare or other governmental benefits, as permitted by law.
- Primary plan: A benefit plan that has primary liability for a claim.
- Secondary plan: A benefit plan that adjusts its benefits by the amount payable under the primary plan.

When you are covered by more than one plan, the primary plan will pay benefits first while the secondary plan will pay benefits after the primary plan has paid benefits.

How Coordination of Benefits Works

- When the Citi Expatriate Plan or Citi Retiree Expatriate Plan is primary: The Plans considers benefits as if a secondary plan does not exist, and it will pay benefits first. Benefits will be calculated according to the terms of the applicable plan and will not be reduced due to benefits payable under other plans.
- When the Citi Expatriate Plan or Citi Retiree Expatriate Plan is secondary: The Plans will pay the difference, if any, between what you would have received from Citi if it were the only coverage and what you are eligible to receive from the other plan. Total benefits will never equal more than what the Plans would have paid alone. Benefits under the Citi Plan may be reduced. The Claim Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted

from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan would have paid alone.

With regard to automobile accidents, this plan **always** pays secondary to:

- Any motor vehicle policy available to you including any medical payments, Personal Injury Protection (PIP) and No Fault; and
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

The Citi Expatriate Plan or Citi Retiree Expatriate Plan will be the primary plan for claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse, if your spouse is not covered as an employee by another plan; and
- For your dependent children, if they are not covered by another plan through their employment or through military service.

Parents' birthdays are used to determine whose coverage is primary for the children. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage. For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is considered the primary plan for your children.

If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

In Case of Divorce or Legal Separation

When a child is claimed as a dependent by parents who are legally separated or divorced, the primary plan is the plan of the parent who has court-ordered financial responsibility for the dependent child's health care expenses. 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; and
- The plan of the parent who does not have custody of the child.

In the event of a legal conflict between two plans over which is primary and which is secondary, the plan that has covered the individual for the longer time will be considered primary. When a plan does not have a coordination-of-benefits provision, the rules in this provision are not applicable and such plan's coverage is automatically considered primary.

Coordination with Medicare

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

- Eligible active employees age 65 and over who are entitled to Medicare benefits whose permanent residence is outside the U.S., Puerto Rico and Canada;

- Dependent spouses age 65 and over who participate in the Citi Expatriate Plan on the basis of current employment status of the employee and who are entitled to Medicare benefits and whose permanent residence is outside the U.S., Puerto Rico and Canada; 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). After this initial 30-month period, the Citi Expatriate Plan is secondary to Medicare, if the participant permanently resides in the U.S., Puerto Rico and Canada.

Facility of Payment

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

Right of Recovery

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

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

With regard to automobile accidents, this Plan **always** pays secondary to:

- Any motor vehicle policy available to you including any medical payments, PIP and No Fault; and
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

Release of Information

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

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

Your HIPAA Rights

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

Your Special Enrollment Rights

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

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

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

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

Notice of HIPAA Privacy Practices

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

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

If you have any questions or want additional information about this notice, call the Citi Benefits Center via ConnectOne. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed under "Contact Information" located at the back of this book.

Component Plans' Responsibilities

Each Component Plan is required by law to maintain the privacy of your protected health information. The HIPAA Privacy Rule defines "protected health information" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, employer or health care clearinghouse; (2) that relates to the past, present or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan.

Component Plans are required to limit the use, disclosure or request for protected health information to the extent practicable to either limited data sets or, if needed, the minimum necessary to accomplish the intended purpose of the use, disclosure or request.

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

Uses and Disclosures of Protected Health Information

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

Payment and Health Care Operations

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

Payment

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

Health Care Operations

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

Business Associates

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

Organized Health Care Arrangement

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

Other Covered Entities

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

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

Required by Law

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

Public Health Activities

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

Health Oversight Activities

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

Lawsuits and Other Legal Proceedings

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

Abuse or Neglect

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

Law Enforcement

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

Coroners, Medical Examiners and Funeral Directors

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

Organ and Tissue Donation

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

Research

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

To Prevent a Serious Threat to Health or Safety

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

Military

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

National Security and Protective Services

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

Inmates

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

Workers' Compensation

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

Disclosures to the Plan Sponsor

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

Others Involved in Your Health Care

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

Disclosures to the Secretary of the U.S. Department of Health and Human Services

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

Disclosures to You

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

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

Other Uses and Disclosures of Your Protected Health Information

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

Contacting You

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

Your Rights

The following is a description of your rights regarding your protected health information. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request using the contact information beginning. As required by law, in the event of an unauthorized disclosure, use or access of your unsecured protected health information, you will receive written notification.

Right to Request a Restriction

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

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

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

Right to Request Confidential Communications

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

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

Right to Request Access

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

You may request an electronic copy of your protected health information if it is maintained in an electronic health record. In addition, you may request a copy of all electronic protected health information maintained in a designated record set in the electronic form and format (e.g., web portal, e-mail or on portable electronic media) in which you and the Component Plan can reach an agreement that such information will be provided. You may also request that such electronic protected health information be sent to another entity or person. Any change that is assessed must be reasonable and based on the Component Plans' cost.

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

Right to Request an Amendment

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

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

Right to Request an Accounting

You have the right to request an accounting of certain disclosures Component Plans have made of your protected health information. You may request an accounting using the contact information located at the back of this book. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

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

Right to a Paper Copy of this Notice

You have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically. To obtain such a copy, call the Citi Benefits Center.

Notwithstanding the permitted disclosures noted above, all participants' PHI is deemed confidential and shall be protected to the fullest extent possible under applicable law. Such disclosure, beyond permitted payment and health care operations, shall not be authorized unless the specific request strictly complies with HIPAA requirements (i.e., court order, subpoena, etc.) with respect to the requested information, and is subject to review by the plan administrator.

Complaints

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

Changes to this Notice

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

Effective Date

This Notice of HIPAA Privacy Practices became effective April 14, 2003, and was reviewed without revision on November 15, 2023.

Contact Information

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

Citigroup Privacy Officer
c/o Global Benefits Department
388 Greenwich St. 15th Floor
New York, NY 10013

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

If You Are Enrolled in Any of These Plans:	Call:
• Citigroup Expatriate Medical Plan • Citigroup Expatriate Dental Plan • Citigroup Expatriate Retiree Medical Benefit Plan • Citigroup Expatriate Retiree Dental Plan	From outside the U.S., Puerto Rico, Canada or Guam Call the HR Shared Services (HRSS) North America Service Center at +1 (469) 220-9600. Press 1 when prompted. From the ConnectOne “benefits” menu, choose the “health and insurance benefits” option and speak to a Citi Benefits Center representative. From within the U.S., Puerto Rico, Canada or Guam Call ConnectOne at +1 (800) 881-3938. From the ConnectOne “benefits” menu, choose the “health and insurance benefits” option and then follow the prompts to speak with a Citi Benefits Center representative. If you use a TDD Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Section 1557 of the Affordable Care Act Grievance Procedure

It is the policy of Citigroup not to discriminate on the basis of race, color, national origin, sex, age or disability. Citigroup has adopted an internal grievance procedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be requested from the office of Citi Global Benefits Department, 388 Greenwich St. 15th Floor, New York, NY 10013.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Citigroup to retaliate against anyone who opposes discrimination, files a grievance or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Citi Global Benefits Department (the Section 1557 Coordinator) within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Citi Global Benefits Department (or their designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Citi Global Benefits Department will maintain the files and records of Citigroup relating to such grievances. To the extent possible, and in accordance with applicable law, the Citi Global Benefits Department will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Citi Global Benefits Department will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.
- The person filing the grievance may appeal the decision of the Citi Global Benefits Department by writing to the Citi Global Benefits Department (Section 1557 Administrator) within 15 days of receiving the decision. The Section 1557 Administrator shall issue a written decision in response to the appeal no later than 30 days after its filing.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201.

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Citigroup will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Citi Global Benefits Department will be responsible for such arrangements.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the Telecommunications Relay Service at 711. Then call ConnectOne.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Citigroup complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Citigroup provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at **+1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the office of Citi Global Benefits Department, 388 Greenwich St.,15th Floor, New York, NY 10013.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at +1(800) 368-1019, +1 (800) 537-7697 (TDD).

Language Assistance

For language assistance in your language call the number on your medical plan ID Card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

Arabic) للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية(.

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی

(Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)

Important Notices

Women's Health and Cancer Rights Act Notice

The U.S. Women's Health and Cancer Rights Act requires that group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies.

If you receive benefits for a medically necessary mastectomy and you elect breast reconstruction after the mastectomy, you will also be covered for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy including lymphedema.

Qualified Medical Child Support Orders (QMCSOs)

As required by the U.S. Federal Omnibus Budget Reconciliation Act of 1993, any child(ren) of a participant under a Citi Medical or Dental Plan who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the medical and/or dental plan.

In general, QMSCOs are U.S. state court orders requiring a parent to provide medical support to an eligible child(ren), for example in the case of a divorce or separation.

To receive a detailed description of the procedures for a QMCSO at no cost or if you have a question about filing a QMCSO, call the Citi Benefits Center.

Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam) and press 1 when prompted, or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

You can file your QMCSO by mailing it or faxing it to:

QMCSO Team
P.O. Box 1542
Lincolnshire, IL 60069-1542
Fax: +1 (847) 442-0899

Genetic Information Nondiscrimination Act of 2008

Under the Genetic Information Nondiscrimination Act of 2008 (GINA), genetic information cannot be requested, required or purchased for underwriting purposes or before enrollment. You and your dependents cannot be required to undergo genetic testing. Genetic information cannot be used to adjust premiums or contributions. The Plan may use the minimum necessary amount of genetic testing results to make determinations about claims payments.

Important Notices about Your Citigroup Prescription Drug Coverage and Medicare

Citigroup has determined that prescription drug coverage provided through the medical options offered by Citigroup, are "creditable" under Medicare.

Creditable Coverage Disclosure Notice

If you and/or your dependents are enrolled in Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices for your prescription drug coverage. See the following information.

For Employees and Former Employees Enrolled in Citigroup Medical Plans

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

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

Prescription Drug Coverage and Medicare

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

'Creditable Coverage'

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

Understanding the Basics

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

- You *have* prescription drug coverage under your current Citigroup medical plan. Your prescription drug coverage under the Citigroup medical plan is considered primary to Medicare if you are a current employee of Citigroup. This means that your Citigroup plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in a Citigroup medical plan, you should consider how Citigroup plan coverage would affect the benefits you receive under the Medicare prescription drug plan.
- If you drop your Citigroup prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citigroup coverage back at a later date. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citigroup coverage is, on average, *at least as good* as standard Medicare prescription drug coverage (this is your "creditable" coverage). As a result, you can keep your current Citigroup coverage and *not* pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an Annual Enrollment period from October 15 - December 7 for coverage effective the first day of the following year.
- If you drop or lose your coverage with Citigroup and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you lose your prescription drug coverage under the Citigroup medical plan, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan.

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

For More Information about Medicare

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

- Visit**www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see your copy of the "Medicare & You" handbook for the telephone number).
- Call+1 (800) MEDICARE (+1 (800) 633-4227); for TDD service, call +1 (877) 486-2048.

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

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

For More Information about this Notice

Call the Citi Benefits Center through ConnectOne. From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option.

For TDD service, call the Telecommunications Relay Services at 711. Then call ConnectOne as instructed above.

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

ERISA Information

As a participant in Citigroup Health and Insurance Plans subject to ERISA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

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

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

If there is a loss of coverage under the Health Plans as a result of a qualifying event, you may continue health care coverage for you, your spouse/partner or eligible dependents. You or your dependents may have to pay for such coverage. Review this SPD and all other documents governing the Plans for the rules governing your continuation coverage rights.

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

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

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

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

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

Answers to Your Questions

If you have questions about the plans, contact the Plan Administrator listed under "Plan administration."

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

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

Recovery Provisions

Refund of Overpayments

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

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

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

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

Reimbursement for Citigroup Health Benefit Plan (Expatriate health coverage is a component of the same)

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

However, if the Plan does pay for or provide benefits for such an injury, sickness or other condition, the Covered Person — or the legal representatives, estate or heirs of the Covered Person — will promptly reimburse the Plan from all recovery amounts (whether or not characterized as related to medical expenses) from any settlement, verdict, or

insurance proceeds received by the Covered Person (or by the legal representatives, estate or heirs of the Covered Person) to the extent that medical benefits have been paid for or provided by the Plan to the Covered Person.

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

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

The Covered Person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The Covered Person also agrees that the Plan Administrator may withhold any future benefits paid by this Plan or any other 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.

To secure the rights of the Plan under this section, the Covered Person hereby:

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

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

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

Subrogation

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

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

The Covered Person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with relevant information requested by them; signing and

delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

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

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

Claims and Appeals

If you do not receive a benefit to which you believe you are entitled under any Citi Health and Insurance Plans that is subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA) or if your application for benefits is denied in whole or in part, you may file a claim with the Plan Administrator or Claims Administrator, as applicable. For more information about the Plan Administrator see "Plan Administrator" and the list of Claims Administrators under "Claims Administrators."

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

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

Important COVID-19-Related Changes that Extend Claims and Appeals Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with COVID-19, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefits, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines will expire 60 days after the end of the National Emergency (which ended on May 11, 2023), meaning July 10, 2023.

If your deadline to file a claim or appeal falls within the National Emergency (March 1, 2020 -May 11, 2023) and you have exceeded the deadlines outlined in your plan documents or denial notification, you may have additional time to submit your request.

For more information, contact the Claims Administrators as detailed under "Claims Administrators" later in this Administrative Information section of the Handbook, or, call the Citi Benefits Center via ConnectOne at +1 (800) 881-3938 for additional help. From the Benefits menu, select the appropriate option. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plans, the Plans' administrators and other fiduciaries of the Plans shall have discretionary authority to interpret the terms of the Plans and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plans. Any interpretation or determination made

pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Medical Care Claims

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

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

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

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

Deciding Initial Medical Benefit Claims

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

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

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

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

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

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

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

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

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

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

If a preservice or post-service claim is incomplete, the Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of Initial Benefit Decision

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

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

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

Appeals

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

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

- The appeal shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt of the appeal.
- The appeal of an urgent care claim shall be decided as soon as possible, taking into account the medical urgency but no later than 72 hours after receipt of the appeal.
- The appeal of a post-service claim shall be decided within a reasonable period but no later than 60 days after receipt of the appeal.

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

Notice of Benefit Determination on Appeal

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

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

External Review

Aetna may deny a claim because it determines that the care is not appropriate or a service or treatment is experimental or investigational in nature. In either of these situations, you may request an external review if you or your provider disagrees with Aetna's decision. An external review is a review by an independent physician, selected by an External Review Organization, who has expertise in the problem or question involved.

To request an external review, the following requirements must be met:

- You have received notice of the denial of a claim by Aetna; and
- Your claim was denied because Aetna determined that the care was not necessary or was experimental or investigational; and
- The cost of the service or treatment in question for which you are responsible exceeds $500; and
- You have exhausted the applicable internal appeal processes.

The claim denial letter you receive from Aetna will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form. You must submit the Request for External Review Form to Aetna within 60 calendar days of the date you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

Aetna will contact the External Review Organization that will conduct the review of your claim. The External Review Organization will select an independent physician with appropriate expertise to perform the review. In making a decision, the external reviewer may consider any appropriate credible information that you send along with the Request for External Review Form, and will follow Aetna's contractual documents and plan criteria governing the benefits. You will be notified of the decision of the External Review Organization usually within 30 calendar days of Aetna's receipt of your request form and all necessary information. A quicker review is possible if your physician certifies (by telephone or on a separate Request for External Review Form) that a delay in receiving the service would endanger your health. Expedited reviews are decided within 3 to 5 calendar days after Aetna receives the request.

Aetna, the Company and the Health Plan will abide by the decision of the External Review Organization, except where Aetna can show conflict of interest, bias or fraud. You are 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 and for the cost of the external review.

For more information about Aetna's External Review process, call the toll-free Customer Services telephone number shown on your ID card.

Eligibility and Enrollment Claims

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

To file an enrollment-related claim and for information on the claim review process, follow the instructions below. Use the Citigroup Employee Benefits Eligibility Claims and Appeals Form available to you at no cost by calling the Citi Benefits Center. Call the HR Shared Services (HRSS) North America Service Center at +**1 (469) 220-9600** (from outside the U.S., Puerto Rico, Canada or Guam), or call ConnectOne at +**1 (800) 881-3938** (from within the U.S., Puerto Rico, Canada or Guam). From the ConnectOne "benefits" menu, choose the "health and insurance benefits" option. Follow the instructions on the form and return the form to the Plans Administration Committee at the fax number or address below:

Plans Administration Committee of Citigroup Inc.
c/o Claims and Appeals Management Team

P.O. Box 1407
Lincolnshire, IL 60069-1407

Fax: +1 (847) 554-1653

Appeals Review Process

The Committee will conduct a full and fair review of your appeal. You and/or your representative may review Plan documents and submit written comments with your appeal. Appeals that are filed at least 30 days prior to the Committee's next quarterly meeting will be decided at that meeting (and appeals filed within 30 days will be decided at the following meeting). If special circumstances apply, you will be notified of an extension and the date the Committee will reach a determination with respect to your appeal. Your appeal will be decided no later than by the third quarterly meeting that follows the receipt of your appeal.

Legal Action

No suit or action for benefits under the Plan shall be sustainable in any court of law or equity, unless you complete the appeals procedure, and unless your suit or action is commenced within 12 consecutive months after the Committee's final decision on appeal, or if earlier, within two years from the date on which the claimant was aware, or should have been aware, of the claim at issue in the proceeding. The two-year limitation shall be increased by any time a claim or appeal on the issue in under consideration by the appropriate fiduciary.

All Other Benefits Claims

In addition, if you file a claim for benefits under the Citigroup Disability, Basic Life insurance, AD&D, GUL, Supplemental AD&D and Business Travel Accident/Medical insurance Plans, generally your claim will be administered in accordance with the timetable described below. For additional details, contact the applicable Claims Administrator.

Notice of Adverse Benefits Determinations

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

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

Appeals

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

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

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

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

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

Notice of Benefit Determination on Appeal

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

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

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

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

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

Regarding Appeals

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;

- The Claims Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures. However, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plans. Notwithstanding any provision of the Plan to the contrary, you must file any lawsuit related to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two-year limitation shall be increased by any time claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan, that period will apply to suits against the insurer.

Future of the Plans and Plan Amendments

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

Citigroup Inc. (or its affiliate, if appropriate) has the right to amend, modify, suspend or terminate any Plan, policy or program, in whole or in Part, at any time, for any reason. Plan amendments shall be adopted and executed by the Senior Human Resource Officer of Citigroup Inc., a Committee of the Board of Directors or Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt Plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements.

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

Plan Administration

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

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

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

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

The delegation by the Plan Administrator may (but is not required to) be in writing. The Plan administrator will administer the Plans on a reasonable and non-discriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of New York will control in all matters relating to the plans.

Plan Information

Plan sponsor	Citigroup Inc. 750 Washington Boulevard, 8th Floor Stamford, CT 06901
Employer identification number	52-1568099
Plan Administrator	Plans Administration Committee of Citigroup Inc. 388 Greenwich St., 15th Floor New York, NY 10013 From outside the U.S., Puerto Rico, Canada or Guam, call the HR Shared Services (HRSS) North America Service Center at **+1 (469) 220-9600**. From within the U.S. Puerto Rico, Canada or Guam, call ConnectOne at **+1 (800) 881-3938**. From the ConnectOne main menu, choose the "Benefits including 401(k), pension, health and insurance, disability and equity" option and then follow the prompts for a Citi Benefits Center representative. **If you use a TDD:** Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.
Agent for service of legal process	General Counsel Citigroup Inc. 388 Greenwich St., 15th Floor New York, NY 10013
Plan year	January 1–December 31
PLAN NAMES AND NUMBERS	
Expatriate Medical Plan: Self-funded including prescription drugs;	Citigroup Health Benefit Plan, Plan #508
Retiree Expatriate Medical Plan: Self-funded including prescription drugs	Citigroup Retiree Medical Benefit Plan, Plan #550
Expatriate Dental Plan (Actives and Retirees)	Citigroup Dental Benefit Plan, Plan #505
Basic Life insurance, Basic AD&D, GUL and Supplemental AD&D	Citigroup Life Insurance Benefits Plan, Plan #506
Business Travel Accident/Medical insurance	Citigroup Business Travel Accident/Medical Plan, Plan #510
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan, Plan #530
FUNDING	
Medical Plan and Dental Plan	The Medical Plan and Dental Plan are funded through insurance contracts, the general assets of Citigroup or a trust qualified under Section 501(c) (9) of the Code on behalf of the Plans. The cost of medical and dental coverage is shared by Citigroup and the participants.
Basic Life, Basic AD&D, GUL, Supplemental AD&D and Business Travel Accident/Medical insurance	Basic Life and Basic AD&D, GUL, Supplemental AD&D and Business Accident Travel/Medical insurance are fully insured. A portion of the Basic Life insurance benefit may be paid from a trust qualified under Section 501(c)(9) of the Code. Generally benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life, Basic AD&D and Business Travel Accident/Medical insurance coverage is provided through employer contributions; GUL and Supplemental AD&D are provided through employee contributions.
Disability Plan	STD coverage is provided by Citigroup; no employee contributions are required. A portion of the LTD benefits are fully insured and a portion are paid from the general assets of the Company. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
Type of administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. However, the final decision on the payment of claims under certain Plans rests with the Claims Administrators.

Claims Administrators

Each of the claims administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of its respective benefit plan, namely, those provisions of the Plan Documents that apply to the participant and are administered by that particular claims administrator.

Medical/Dental and Prescription Drug Coverage	Aetna International Citigroup Claims Division P.O. Box 981543 El Paso, TX 9998-1543 +**1 (800) 231-7729**
Basic Life	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 **+1 (800) 638-6420**
Basic Accidental Death and Dismemberment (AD&D) and Supplemental AD&D	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 **+1 (800) 638-6420**
Group Universal Life	Metropolitan Life Insurance Company — Group Life Claims PO Box 6100 Scranton, PA 18505-6100 **+1 (800) 638-6420**
Business Travel Accident/Medical	Chubb USA PO Box 5124 Scranton, PA 18505-0556 ACEAandHClaims@chubb.com **Inside the US** 1 (800) 336 0627 **Outside the US** **+1 (302) 476 6194** **Fax** +1 (302) 476 7857
Short-Term Disability and Long-Term Disability	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 +**1 (888) 830-7380**

Glossary

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

In-network provider (applies to U.S. only): A health care provider on a list of providers preselected by the insurer (Aetna International). The insurer will offer discounted coinsurance or copayments to a plan member to use network providers and facilities.

Maximum allowed amount (MAA): Any charge that, for services rendered by or on behalf of an out-of-network physician, does not exceed the amount determined by the Claims Administrator in accordance with the applicable fee schedule.

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

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

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

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

Out-of-pocket maximum: The limit to the amount you will pay in a Plan Year if you or your family incurs large and unusual medical bills. Once the maximum out-of-pocket amount has been met, the Plan will pay 100% of the maximum allowed amount (MAA) charges. If the expenses incurred are higher than the MAA charges, the individual receiving the service is responsible for paying the difference even if the out-of-pocket maximum has been reached. Note that there are separate out-of-pocket maximums for medical and for prescription drug expenses.

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

Wellness services: Charges for routine care exams are based on the guidelines from the American Medical Association and doctor recommendations. Covered expenses include routine physical exams (including well-woman and well-child exams) and immunizations.

Telephone Numbers and Website Addresses

For all Expatriate Benefit related questions, coverage changes, etc. contact the Citi Benefits Center and ask to speak with an Expatriate Benefit Representative.	From outside the U.S., Puerto Rico, Canada or Guam: +**1 (469) 220-9600** and press 1 when prompted From within the U.S, Puerto Rico, Canada or Guam.: +**1 (800) 881-3938** From the ConnectOne main menu, choose the "Benefits including 401(k), pension, health and insurance, disability and equity" option. Representatives are available from 8 a.m. to 8 p.m. Eastern time Monday through Friday.
Expatriates have access to Your Benefits Resources™ (YBR™) via My Total Compensation and Benefits to access coverage information, update dependent information and print copies of your auto enrollment.	Visit **My Total Compensation and Benefits** at www.totalcomponline.com. Expatriates can log on using their User ID and Single Sign-on

Aetna International Member Services Aetna International can provide information about medical and dental coverage, referrals to providers outside the U.S., and the names of providers in the Aetna International medical network in the U.S., and how to file claims and claim appeals. You can register for website access online or by calling toll free. **Mail:** Aetna International P.O. Box 981543 El Paso, TX 79998-1543 USA **Overnight delivery:** Attention: Aetna International/Aetna 7777 Market Center Ave., Suite E El Paso, TX 79912-8411 USA **Phone:** **+1 (915) 877-7032** (UPS, FedEx and DHL require a contact phone number)	**Call:** • **Toll free: +1 (888)** 633-1149 (Refer to the AT&T International Calling Guide in your member kit) • **Direct: +1 (813) 775-0190**. (Collect calls accepted) **Fax:** • Toll free: +1 (800) 475-8751 • Direct: +1 (813) 775-0625 **Email:** AiService@aetna.com **On the web:** **www.aetnainternational.com** **To call the Aetna International Center toll free from a non-U.S. location:** • Locate your country's AT&T Direct Access Number* listed for the country from which you are calling; call **+1 (813) 775-0190** collect if the country is not listed. • When prompted for the number you are calling, dial **+1 (800) 633-1149** (You do not need to dial "1" before the area code.) • After the tone, you will hear an automated message stating "Thank you for using AT&T," and your call will be directed to the Aetna International Service Center. *Refer to the AT&T International Calling Guide provided in your member kit or visit the AT&T website at www.att.com/business_traveler for the most recent international toll-free dialing instructions and access codes.
Basic Life insurance/Accidental Death and Dismemberment (AD&D) insurance **(Citi Benefits Center)**	**From outside the U.S., Puerto Rico, Canada or Guam:** Call **+1 (469) 220-9600** and press 1 when prompted **From within the U.S., Puerto Rico, Canada or Guam:** Call **+1 (800) 881-3938** From the ConnectOne main menu, choose the "Benefits including 401(k), pension, health and insurance, disability and equity" Representatives are available from 8 a.m. to 8 p.m. Eastern time Monday through Friday.
Group Universal Life (GUL) and Supplemental Accidental Death and Dismemberment (AD&D) insurance • To enroll in coverage or make changes • General information/questions • To continue an individual policy	From in and outside the U.S.: Call +1 (888) 830-7380
Business Travel Accident/Medical insurance (BTA) (Chubb Insurance Company)	From outside the U.S.: Call **+1 (302) 476-6194** From within the U.S.: Call **+1 (800)336-0627** 8 a.m. to 4:30 p.m. Eastern time Monday through Friday
Disability (MetLife) To report a disability and for information about Short-Term Disability (STD) and Long-Term Disability (LTD) benefits	From in and outside the U.S.: Call **+1 (888) 830-7380**

COBRA **(Consolidated Omnibus Budget Reconciliation Act of 1985, as amended)** For information on continuing medical and dental coverage for up to 18 months.	From in and outside the U.S., Puerto Rico, Canada or Guam: Call **+1 (469) 220-9600**, and press 1 when prompted From within the U.S., Puerto Rico, Canada or Guam: Call **+1 (800) 881-3938** From the ConnectOne main menu, choose the "Benefits including 401(k), pension, health and insurance, disability and equity" Representatives are available from 8 a.m. to 8 p.m. Eastern time Monday through Friday.
Expatriate Program Support page of *Citi For You* website For information about plan benefits and forms	https://citiforyou.citigroup.net/en-us/Pages/BN-ExpatProgram.aspx

This Handbook is intended to provide a brief overview of your Citi Expatriate health and insurance coverage for both active employees and eligible retirees. It briefly summarizes certain key features of Citi benefits for eligible Expatriate employees/retirees and their dependents and is treated as a Summary of Material Modifications under ERISA, but it does not provide detailed information. If a provision in this Handbook or any oral representation differs from a provision of the applicable plan document, summary plan description or contract, the applicable plan document, summary plan description or contract will control.

Citi reserves the right to change or to discontinue any or all of the benefits coverage or programs described here at any time. No statement in this or any other document and no oral representation should be construed as waiving this right.

Nothing in this or any other benefits documents or any oral representation should be construed as a guarantee of employment for any period of time.