BENEFITS 2008: CHOOSING YOUR CITIGROUP BENEFITS

Puerto Rico edition

INSIDE FRONT COVER

Citigroup offers a variety of health and insurance benefits so you can customize a comprehensive program that fits your needs. The enclosed materials describe the health and insurance benefits available in 2008.

See your Benefits 2008 Personal Enrollment Worksheet for instructions on when and how to enroll by telephone or via the Citigroup intranet or the Internet.

If you need information about benefits coverage that is not included in this book, contact the health plans directly as explained in the "Telephone and Web site directory" on page 85 or call ConnectOne at 1-800-881-3938. You can choose to hear the enrollment menu in Spanish or in English. From the ConnectOne main menu, choose the "health and welfare benefits" option and follow the prompts for the Benefits Service Center. Representatives are available from 8 a.m. to 8 p.m. Eastern time on weekdays, excluding holidays.

Contents

Important information about the contents of this document

This document describes health and welfare benefits for certain Puerto Rico employees of Citigroup Inc. ("Citigroup") and its participating companies (collectively the "Company") as in effect January 1, 2008. The benefits described in this document are:

- Citigroup Medical Plans
  - Triple-S Preferred Provider Organization (PPO) Plan and
  - Citigroup Prescription Drug Program.

- Citigroup Dental Plans
  - Triple-S Dental Plan

- Citigroup Vision Benefit Plan;
- Employee Assistance Program;
- Citigroup Disability Plan;

- Citigroup Life insurance benefits
  - Basic Life Insurance and Accidental Death and Dismemberment (AD&D);
  - Optional Group Universal Life Insurance and Supplemental AD&D; and
  - Business Travel Accident Insurance (BTA);
- Long Term Care Insurance.

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 about your prescription drug coverage. Please see page 53 for more details.

The document serves as a summary plan description (SPD) for the health and welfare benefit plans described above (the "Citigroup Health and Welfare Plans or collectively the "Plans" and individually a "Plan").

This summary has been written, to the extent possible, in non-technical language to help you understand the basic terms and conditions of the Plans as they are in effect. This description is intended only to be a summary of the major highlights of the Plans.

The Plans are subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). To the extent applicable, the Plans will be interpreted and administered in accordance with ERISA and applicable law.

No general explanation can adequately give you all the details of the Plans. This general explanation does not change, expand, or otherwise interpret the terms of the Plans. If there is any conflict between this SPD, or any written or oral communication by an individual representing the Plans, and the Plan documents (including any related insurance contracts), the terms of the Plan documents — including any related insurance contracts as interpreted in the sole discretion of the Plan Administrator — will be followed in determining your rights and benefits under the Plans.

Citigroup may change or discontinue the Plans or any part thereof at any time without notice.

The summary information is general in nature and is not meant as tax advice. Citigroup Inc. and its affiliates are not in the business of providing personal tax or legal advice to its employees. Any such taxpayer should seek advice based on the taxpayer’s particular circumstances from an independent tax adviser.

Instructions

Review your benefits materials, in particular your Personal Enrollment Worksheet, which lists the cost of coverage, your enrollment instructions, and enrollment deadline.

- If you want to enroll in Citi coverage, you *must* enroll during the enrollment period shown on your Personal Enrollment Worksheet.
- If applicable, call to confirm that a network provider will continue in the plan's network next year.
- You must actively enroll within 31 days of your date of hire or date of eligibility. Your deadline will be printed on your Personal Enrollment Worksheet.

What happens if you do not enroll

If you do not enroll for 2008, you must wait until the next annual enrollment period or you have a qualified change in status to enroll in medical, dental, or vision coverage. See page 15 for information on qualified changes in status.

How to enroll

You can link to the Citi Benefits Web Site through Total Comp @ Citi at **www.totalcomponline.com**. If you are a new employee, your information will not be available on Total Comp @ Citi until approximately two months after your date of hire. Instead, go directly to **https://mybenefits.csplans.com**

You also can enroll by telephone. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center. Your enrollment deadline is shown online and on your Personal Enrollment Worksheet.

Enrollment in Triple S Medical and Dental

If you elect both medical and dental coverage, you must enroll in the same coverage tier for both benefits. If you cover dependents in both medical and dental plans, you must cover the same dependents.

Benefits overview

Citi provides a basic level of benefits coverage (core benefits) as well as the opportunity to enroll in additional coverage. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than for the core benefits, described immediately below, you must enroll to have coverage.

Core benefits, provided at no cost to you, are:

- Basic Life insurance that includes Accidental Death and Dismemberment (AD&D) insurance, each equal to your total compensation, up to $200,000, on your date of eligibility. Basic Life insurance is administered by MetLife, while AD&D is administered by CIGNA;
- Business Travel Accident insurance, administered by AIG, of up to five times your total compensation to a maximum benefit of $2 million;

- Short-Term Disability (STD) coverage, administered by MetLife, to replace up to 100% of your annual base salary for an approved disability leave of up to 13 weeks; the number of weeks at 100% pay will depend on your length of service with Citi. See page 34 for the STD schedule of benefits;
- Long-Term Disability (LTD) coverage, administered by MetLife, equal to 60% of your total compensation. This is a core benefit if your total compensation is less than or equal to $50,000.99. If your total compensation is $50,001 and above and you want to enroll in LTD coverage, you must pay for it.
- Employee Assistance Program, administered by Harris Rothenberg International, LLC provides confidential counseling and referral services to assist employees with various life issues.

Additional benefits, which you will want to consider based on your individual and family circumstances, are:

- Medical;
- Dental;
- Vision ;
- Long-Term Disability (LTD), if your total compensation is $50,001 and above. **Note:** If your total compensation is $50,000.99 and under, LTD is a core benefit provided at no cost to you;
- Optional Group Universal Life (GUL) insurance and Supplemental Accidental Death and Dismemberment (AD&D) insurance; and
- Long-Term Care insurance.

Confirmation of enrollment

If you enroll by telephone, a confirmation statement will be mailed to your home between one and three weeks after you enroll. Your confirmation statement will list your benefit elections for 2008 and their costs. Review this confirmation statement carefully for accuracy, and retain it as proof of your enrollment. If you find an error, call the Benefits Service Center immediately.

If you need to use a medical provider (doctor or hospital) before you receive your health plan ID card, use your confirmation statement as proof of 2008 coverage along with the Triple-S group number (1-03450).

If you enroll online, print the confirmation screen after you enroll for your records. You also will receive a confirmation statement in the mail.

Confirmation of default

If you do not enroll, you will receive a default statement within several weeks after your enrollment deadline. The default statement will list your 2008 Citi benefits (if any) that will continue through 2008 and their costs. Retain this statement as proof of any 2008 coverage you may have.

Beneficiary forms

Your beneficiary information should be on file with Citi. If you have never designated a beneficiary (either by completing a form or visiting the Your Benefits Resources™ Web site,

you should visit **http://resources.hewitt.com/citigroup/**. Most employees also can link to Your Benefits Resources through Total Comp @ Citi at **www.totalcomponline.com**.

You also can call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "pension and retiree health and welfare" option. Then follow the prompts for "pension beneficiary information" to name a beneficiary for Basic Life (including AD&D) insurance, the Citibuilder 401(k) Plan for Puerto Rico, Citigroup Pension Plan, and, if applicable, the Citigroup 401(k) Plan

If you enroll in Optional GUL insurance for the first time, you must complete a MetLife Beneficiary Designation-Form 201 available at **http://www.citigroup.net/human_resources/form.htm** and return it to MetLife at the address on the form. Your beneficiary for Optional GUL will apply to the Supplemental AD&D coverage.

If you change your beneficiary designation for either Basic Life or Optional GUL, it will not automatically apply to the other Plans. You must change the beneficiary for each Plan separately.

Eligibility

You are considered an eligible Puerto Rico employee eligible for health and welfare benefits if:

- You work in the Puerto Rico for Global Consumer Group, Global Wealth Management, Citi Markets & Banking, and Citigroup Corporate Center, and their participating businesses.

- You are an active[1]:
  - Full-time employee (regularly scheduled to work 40 hours or more a week) **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week);

- You receive regular semimonthly or monthly pay;

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

When you are not eligible to enroll

You are not eligible to enroll in the Plans if:

- Your compensation is not reported on a Form 499R-2/W-2 PR (commonly known as a Form W-2) issued by a participating business;
- You are employed by a Citigroup subsidiary or affiliate that is not a participating business;
- You are engaged under an agreement that states you are not eligible to participate in the applicable Plan or program; or
- You are classified by Citigroup as an independent contractor or consultant.

[1] If you are on an approved leave of absence, you may be eligible to enroll in Citigroup benefits (other than Optional GUL, and Long-Term Care insurance); other enrollment restrictions may apply.

No pre-existing condition limitations

None of the Citigroup medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling in the Plans or receiving benefits for a specific condition or illness.

Definition of eligible dependents

- Your lawfully married spouse; if you are legally separated or divorced, your spouse is *not* an eligible dependent;
- Your domestic partner; see "Domestic partner benefits" beginning on page 18 for details;
- Your domestic partner's eligible dependents; see "Domestic partner benefits" beginning on page 18 for details;
- Your unmarried children who rely on you for financial support and are:
  - Your biological children;
  - Your legally adopted children;
  - Your stepchildren; or
  - Other children who are permanently living with you in a regular parent-child relationship (or who live away at school) and who are primarily dependent on you for financial support and for whom you are his/her legal guardian, in accordance with the laws of Puerto Rico.

You can cover your children if they are:

- Under the age of 19 as of December 31 of the plan year that precedes the enrollment year; or
- Under the age of 25* as of December 31 of the plan year that precedes the enrollment year, and attend an accredited school or college full time (according to the school's or college's definition of full time); *you must provide proof of student status in writing upon request;*
- Handicapped in which case they may be eligible for coverage beyond age 25; handicapped children are eligible for coverage beyond age 25 only if they had Citigroup coverage prior to age 25 or
- Are a handicapped adult when you began employment and you enrolled your child when you were first eligible to do so.

During your enrollment, you will be prompted to certify that your eligible child is a student according to the definition above. In addition, at the start of each semester (August 1 and January 1) you will be required to provide student certification documentation to Triple-S by September 1 and February 1. If appropriate documentation is not received, the student's coverage will be terminated September 1 or February 1.

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. If your dependent child accepts a job at Citigroup and is benefits eligible, you must drop your child from your coverage and your child must enroll in his or her own employee benefits.

* Coverage will be terminated at the end of the plan year in which the child turns 25, if he/she continues to be a full-time student.

Paying for your benefits

In addition to paying for core benefits, Citigroup contributes toward the cost of medical and dental coverage for you and your dependents. You will find the cost to enroll in all coverage categories on your Personal Enrollment Worksheet.

Your contribution for medical coverage will depend on the amount of your total compensation and your coverage category.

Total Compensation and your benefits

Total compensation is used to determine:

- Medical contributions;
- LTD benefits and, where applicable, LTD contributions;
- Basic Life/AD&D insurance benefits;
- Optional GUL/Supplemental AD&D insurance and costs;
- STD for Financial Advisors, Financial Advisor Associates, and Investment Associates in Global Wealth Management and Account Executives in Citi Markets & Banking; and
- Business Travel Accident insurance benefits.

Definition of total compensation

If you are enrolling in benefits as a new hire or newly eligible employee: Your total compensation at the time you are hired is equal to your annual salary. If you are to be paid on commissions only, your total compensation is calculated differently, either based on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

For future years, your total compensation will be based on a formula that includes your actual base pay plus commissions performance-based bonuses, and annual incentive bonus. **Note:** Your total compensation does not necessarily equal the amount reported as salaries and wages on your Form W-2 .

If you are enrolling during the annual enrollment period for coverage effective January 1, 2008: Your Total Compensation for purposes of benefits enrollment is made up of the following:

1. Annual base pay as of July 1, 2007;
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, 2006, will be used for the 2008 annual enrollment calculations;
3. Cash bonus (other than the cash portion of any annual discretionary 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, 2006, excluding the cash portion of the annual discretionary award package dated January 2006, will be used for the 2008 annual enrollment calculations;
4. Annual discretionary award package dated in the year of enrollment (includes the following if applicable: cash bonus, Capital Accumulation Program [CAP] Basic Award, and, for employees with discretionary award packages valued at $500,000 and above, Supplemental

CAP Award; annual discretionary award packages dated January 2007 will be used for 2008 annual enrollment calculations; and

5. Short-Term Disability benefits paid from January 1, 2006, through December 31, 2006, for employees paid commissions only.

For new hires: Any guaranteed bonus will be considered in the calculation of your total compensation for benefit purposes.

For Global Wealth Management Financial Advisors

In your first year of employment, your total compensation is considered to be $60,000. If you earned more than $60,000 at a previous employer in the prior year and want your insurance coverage to represent your prior earnings, you must provide a copy of your previous year's Form W-2 to your HR representative within 30 days of your hire date. *Providing a copy of your previous year's Form W-2 is optional.*

If you provide a copy of your W-2 form, your Basic Life insurance amount will be set at the higher amount (up to $200,000) shown on the form. Your contributions for medical coverage, Optional GUL amount, and LTD benefits and contributions also will be based on the higher amount.

Your decision to have your total compensation set at $60,000 or your actual amount is irrevocable and applies only in your first year of employment.

Coordination of benefits

Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citigroup Plan and one or more other plans, such as a spouse's or other employer's plan.

The Citigroup Medical Plan, the Citigroup Dental Plan, and the Citigroup Vision Plan contain a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable Plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the Plan documents.

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 Citigroup Plan is primary:** The Citigroup Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first.

- **When the Citigroup Plan is secondary:** The Citigroup Plan will pay the difference, if any, between what you would have received from Citigroup 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 Citigroup Plan would have paid alone.*. If a service is not covered or coverage is denied, you will be responsible for payment.

The Citigroup 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 enrolled in a Citigroup plan as an eligible dependent and is not covered as an employee by another plan; and
- For your dependent children.

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 separation

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

- The plan of the parent with custody of the child;
- The plan of the spouse of the parent with custody of the child;
- The plan of the parent 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.

Coverage categories

Citigroup offers four coverage categories from which you may choose to enroll for medical, dental, and vision coverage:

- Employee only: Coverage for you only;
- Employee plus spouse/domestic partner: Coverage for you and your spouse/domestic partner only;
- Employee plus child(ren): Coverage for you and your eligible child(ren) including eligible children of your domestic partner;
- Employee plus family: Coverage for you, your spouse/domestic partner, and your eligible child(ren) including eligible children of your domestic partner.

You can change your coverage category during the annual enrollment period and within 31 days of a qualified change in status.

Qualified changes in status

You must report to Citigroup any change of status that affects your benefits within 31 days of the qualified change by following the process described under "How to report a qualified change in status event" below. Do not report qualified changes in status to your medical plan. Your medical plan must receive any status changes from Citigroup, not from you.

Depending on the event, you can enroll in or cancel your medical, dental, vision care, LTD, Optional GUL/Supplemental AD&D coverage. For Optional GUL, you may increase your existing coverage if the first, second, third, or sixth bullet below applies. Initial election of spousal/domestic partner or child coverage under this program is available if the first, second, or third bullet below applies.

Examples of qualified changes in status are:

- Your marriage, legal separation, or divorce;
- Meeting the eligibility to qualify as a domestic partner;
- The birth or adoption of a child;
- The loss of coverage eligibility for a dependent child who attains a certain age, gets married, obtains a full-time job, or recovers from a disability;
- The loss of coverage under your spouse's/domestic partner's other employer's plan;
- The death of a spouse/domestic partner or dependent child;
- The issuance of a qualified medical child support order (QMCSO);
- Relocation outside your medical and/or dental plan's network area; and
- Beginning of your military leave of absence.

Reporting a qualified change in status event

You have 31 days beginning the day after the event to report the name, date of birth, and Social Security number (if available) for the dependent(s) you want to add or remove from your coverage. If you are adding a newborn who does not yet have a Social Security number, you can report all other information within 31 days and report the Social Security number when you obtain it.

You also must report a new dependent even if you are already enrolled in Citigroup family medical, dental, and/or vision coverage. Without dependent information on file, your new dependent's claims will *not* be paid even if you already have family coverage.

To report a qualified change in status:

- Call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option. From the Benefits Service Center main menu, choose the option to change your coverage for the current year. You can report most changes by following the prompts. However, you must speak with a representative to report a divorce or the death of a dependent.
- Visit Total Comp @ Citi at **www.totalcomponline.com.** From the "quick links" page, click on the link for the Citigroup Benefits Web Site.

Changing your coverage category

When reporting a new dependent whom you want to cover, you may have to change your coverage category. For example, if you are enrolled in medical coverage under the "employee only" category and then you get married and want to cover your new spouse, you must report your new spouse *and* change from "employee only" to the "employee plus spouse/domestic partner" coverage category. A change from "employee only" to any other coverage category will cost more money.

Remember, you must report the addition of a dependent even if you already have family coverage; otherwise, your new dependent will not be covered and his or her claims will not be paid.

Change in Status Worksheet

You can review the Change in Status Worksheet-Form 308, which lists status events and the corresponding changes you can make to your benefits coverage for each event. To obtain a Change in Status Worksheet, visit the "Forms" section of the You @ Citigroup site at **www.citigroup.net/human_resources/form.htm** (intranet only).

Deadline to report qualified changes in status

You must report or revise dependent information and change your coverage or coverage category, if necessary, within 31 days beginning the day after the qualified change in status. Otherwise, you will *not* be able to change your coverage or coverage category until the next annual enrollment period or until you have another change in status event, whichever comes first.

Plan changes you can make at any time

You can cancel, enroll in, or change the following coverage at any time.

- LTD: You can enroll at any time but you must provide evidence of good health except when enrolling as a new hire, when your total compensation increases above $50,000.99 (so that you must pay if you want to continue LTD coverage), or as a result of certain qualified changes in status. However, unless you were enrolled in a prior employer's group plan three months prior to your hire date at Citigroup, 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 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.

- Optional GUL/Supplemental AD&D: For the GUL portion of the benefit, MetLife will require evidence of good health if you want to:
  - Enroll for the first time (other than during your initial enrollment period as a new hire or newly eligible for Citigroup benefits); or
  - Increase your coverage amount.

  Note: CIGNA administers the AD&D portion of the benefit and does not require evidence of good health.

- Long-Term Care insurance: If you enroll at any time other than your initial enrollment period as a new hire, John Hancock will require evidence of good health before coverage will be approved.

Domestic partner benefits

Citigroup offers benefits coverage to your certified unmarried domestic partner of the same or opposite sex. You may cover your domestic partner and his or her eligible children under the following Plans:

- Medical,
- Dental;
- Vision ;
- Optional GUL/Supplemental AD&D insurance for domestic partners and life insurance for children;
- Long-Term Care insurance, available to your domestic partner even if you do not enroll in the Plan.

You may enroll your domestic partner and his or her eligible children in the medical and/or dental plan in which you enroll. You may enroll your domestic partner in spouse/domestic partner Optional GUL/AD&D insurance, Long Term Care Insurance, and/or the Vision Care Plan even if you do not enroll in those Plans

Note: None of the Citigroup medical options has a pre-existing condition limitation or exclusion that would prevent you from enrolling your domestic partner in the Plan or from your domestic partner receiving benefits for a specific condition or illness.

When you can enroll your domestic partner in Citigroup coverage

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

- Upon completing a Certification of Domestic Partnership form, available through the Benefits Service Center, and submitting the required supporting documentation;
- The birth or adoption of a child; and
- Your domestic partner's loss of benefits coverage in another employer's plan.

Eligibility

You are eligible to enroll your domestic partner in Citigroup coverage if you are a Puerto Rico employee who is active or on an approved leave of absence. However, if you are not actively at work, you cannot enroll your domestic partner in Optional GUL or Long-Term Care insurance until after you return to work.

To be eligible for coverage, you and your partner may be of the same or opposite sex, and both of you must meet the following criteria:

- You currently share a principal residence and intend to do so permanently;
- You have lived together for at least six consecutive months prior to enrollment;
- 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;
- Both of you are at least 21 years old and mentally competent to consent to contract;

- You are not related by blood to a degree of closeness that would prohibit marriage were you of the opposite sex;
- Neither you nor your domestic partner is in a domestic partnership with anyone else;
- You have mutually agreed to be responsible for each other's common welfare; and
- You are in a relationship intended to be both permanent and one in which each is the sole domestic partner of the other.

You must provide the Benefits Service Center with any documents necessary to verify your Domestic Partnership. Your Domestic Partner will not be eligible for Citigroup coverage until the documentation is received and approved. As evidence of Domestic Partnership you must provide at least two (2) of the following

- A joint mortgage or lease;
- Designation of the domestic partner as beneficiary for life insurance or retirement benefits;
- Joint wills or designation of the domestic partner as executor and/or primary beneficiary;
- Designation of the domestic partner as your agent under a durable power of attorney or health care proxy;
- Ownership of a joint bank account, joint credit cards, or other evidence of joint financial responsibility;
- Joint title to property or business assets;
- Cosigned lease or loan;
- Evidence of shared residence: utility bill, bank statement, driver's license; or
- Other evidence of economic interdependence.

To cover a domestic partner, you must first complete an Affidavit of Domestic Partnership, which is available by calling the Benefits Service Center. If your domestic partnership ends, you must complete a Affidavit of Termination of Domestic Partnership. To add a new domestic partnership, you must wait six months from the time you filed the Affidavit of Termination of Domestic Partnership.

The children of your domestic partner are eligible for coverage if they:

- Are the biological or adopted children of your domestic partner, children for whom your domestic partner has legal guardianship, or children who have been placed in your home for adoption; and
- Are living with you and your domestic partner on a full-time basis or living away at school; and
  - Are under the age of 19[1] as of December 31 of the plan year that precedes the enrollment year; or
  - Are under the age of 25[1] as of December 31 of the plan year that precedes the enrollment year and are full-time students at an accredited school or college; (during enrollment each year, you will be prompted to certify that your domestic partner's eligible child is a students; you also must provide proof of student status in writing upon request);
  - Were covered under the Plans before age 19, or age 25 as full-time students, and became incapable of self-sustaining employment due to a disability, in which case they may be eligible for coverage beyond such age; or
  - Are a disabled adult when you began your employment with Citigroup and you enrolled your child when you were first eligible to do so.

[1] Coverage will remain in effect through December 31 of the year in which the child becomes ineligible or turns 25.

Your taxes may be affected when you enroll your domestic partner in Citigroup coverage. For information on how tax laws may apply to your personal situation, consult your tax adviser.

However, generally, if you enroll your domestic partner or your partner's children in Citigroup coverage, the value of their coverage is considered income to you.

This additional income, known as "imputed income," will be shown on your annual pay statement for the year in which coverage was effective. You'll be required to pay taxes on this additional income.

Example:
Total Citigroup cost for Employee Only coverage is $175 per month. Total Citigroup cost for Employee + Spouse//Domestic Partner coverage is $350;

The $175 cost for partner coverage will be treated as taxable income to you. This amount is known as imputed income.

Maternity benefits

Group health plans and health insurance issuers generally may not, under 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, 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 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.

Women's Health and Cancer Rights Act notice

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to cover reconstructive surgery and prostheses following mastectomies. All medical plans provide this coverage, subject to applicable deductibles and coinsurance set forth herein.

If you receive benefits for a medically necessary mastectomy, and if you elect breast reconstruction after the mastectomy, you also will 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 federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Medical Plan, Citigroup Dental Plan, or Citigroup Vision Plan who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Plans.

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

Call the Plan Administrator to receive, at no cost, a detailed description of the procedures for a QMCSO. However, if you have a question about filing a QMCSO, call the Benefits Service Center as instructed on page 85. You can file your QMCSO by mailing it to:

Citigroup QMCSO Administration
P.O. Box 56757
Jacksonville, FL 32241-6757

Medical

Citigroup offers coverage in Puerto Rico through Triple-S, a preferred provider organization (PPO). This plan does not have a pre-existing condition limitation or exclusion.

Triple-S PPO

In brief, the PPO allows you a choice each time you need medical care. You can choose a network provider and make a copayment for each visit, or you can choose an out-of-network provider and meet an annual deductible before the plan will pay any benefits. You will pay more out of your pocket when using an out-of-network provider.

The Triple-S PPO gives you the freedom to choose any doctor or hospital — without a referral — when you need medical treatment. The choice is always yours.

When you visit a doctor who participates in the PPO network, you will pay a $10 copayment for each office visit to a generalist physician, specialist, or sub-specialist.

PPO network features

- Triple-S has a network of providers throughout Puerto Rico.
- Triple-S is a member of the Blue Cross and Blue Shield Association. Access to providers in the United States and around the world is available through the BlueCard ® Program and BlueCard® Worldwide.
- You may visit a specialist at any time without a referral.
- For a network hospital admission or hospitalization, the plan will pay 100% of covered charges after a copayment of $150 ($50 for partial hospitalizations).
- Most outpatient services are covered after paying 10% coinsurance.
- You do not need to file a claim for covered services delivered by a network provider.

Preventive care

Preventive care services are available in the Triple S PPO Plan.

Annual allowance: Each participant has an annual allowance toward routine periodic exams performed in the Santurce Medical Mall in San Juan or in the Servicio de Salud Industrial de Ponce.

Routine physical exams, routine ob-gyn exams, and other preventive services are covered at 100% up to $300 (Santurce) or $295 (Ponce) annually.

Services available at these centers include the following:

- Clinical history;
- Physical exam;
- Vision exam;
- Audiometry;
- Spirometry;
- Chest X-ray;
- Comprehensive metabolic panel;

- Complete blood count;
- Liver profile;
- Lipid profile;
- Urinalysis;
- Thyroid stimulating hormone;
- Occult blood in stools test;
- Prostate Specific Antigen;
- Electrocardiogram (EKG);
- Coronary risk profile;
- Tension Management Inventory; and
- Final interview.

The preventive allowance provides a one-time visit only during the contract year. That visit includes all the services provided by that specific center. During that visit the participant will receive all the services included in the package. No subsequent visits are permitted.

Cancer screenings and well-child immunizations: Both cancer screening tests and well-child immunizations performed by network providers are covered at 100% after your copayment.

Preventive care services include:
- Routine physical exams and diagnostic tests, for example, CBC (complete blood count), cholesterol blood test, and urinalysis;
- Well-child-care services such as routine preventive pediatric care; and
- Routine well-woman exams such as routine ob-gyn visits.

Cancer screening tests are:
- PAP smear;
- Mammography;
- Sigmoidoscopy;
- Colonoscopy; and
- PSA test.

Infertility

The Triple S PPO Plan covers the medical and prescription drug expenses associated with infertility treatment. The medical infertility treatment includes in-vitro fertilization, artificial insemination, GIFT, ZIFT, and other non-experimental/investigational treatments.

The infertility benefit covers:
- Prescription drug expenses (managed by Caremark) associated with infertility treatment up to a $7,500 family lifetime maximum for participants. This maximum is combined with any infertility benefits used under the U.S. Prescription Drug Program and

Medical expenses up to a $24,000 family lifetime maximum. This maximum is combined with any infertility benefits used in any of the U.S non-HMO/EPO. medical plans.

For the donor, the Plan covers the cost of physical lab work including genetic testing, psychological evaluations, medications to synchronize the cycle of the donor with the cycle of

the recipient and to stimulate the ovarian function of the donor; all office visits; ultrasound; lab work normally done on the Plan participant; and the harvesting of her eggs.

The lifetime maximum per family can be spent in one year or over a number of years. If you become a U.S. employee, the Plan administrators and Triple S will keep track of the amount you have remaining toward this benefit.

Call your Plan if you have questions about specific procedures or treatments.

PPO out-of-network features

- You must meet an annual $50 individual deductible ($150 family) before the plan will pay any benefits.
- Most covered expenses are reimbursed at 80% of reasonable and customary charges after the annual deductible is met.
- You must notify Triple-S before undergoing certain procedures and receiving certain services.
- You must file a claim to be reimbursed for covered expenses delivered by out-of-network providers.
- The plan has a $1 million lifetime maximum benefit for out-of-network benefits.
- The annual out-of-pocket expense maximum will be $3,000 for an individual and $6,000 for a family.

MEDICAL PLAN FEATURES

		Network coverage	**Out-of-network coverage**
Plan facts	**Member Services**	**1-787-749-4777**	
	Member Services hours	**7 a.m. to 7 p.m.**	
	Web address	**http://www.ssspr.com**	
Your medical expenses	**Annual deductible**	**None**	$50
	Out-of-pocket maximums	**None**	$3,000 individual/$6,000 family
	Office visits	Covered at 100% after a $10 copayment	**80% of R&C after deductible if services are rendered outside PR; covered by reimbursement based on Triple-S established fee if services are rendered in PR by out of network Providers.
	Maternity care/prenatal office visits	Covered at 100% after a $10 copayment	Same as above**
	Inpatient hospitalization	Covered at 100% after a $150 copayment	Same as above**
	Outpatient surgical care		
	Surgical care	Covered at 100%	Same as above**

	Lab and X-ray	Covered at 90%	Same as above**
	Temporomandibular joint treatment	Covered at 90%	Same as above**
	Emergency/urgent care	$25 copayment per visit (waived if admitted)	Same as above**
Preventive care The preventive care allowance is per person, per contract year. This benefit refers to a specific package of services contracted with these providers	Routine physical, well-child care, gyn exam, routine vision exam, and lab and X-rays at Santurce Medical Mall and at Servicio de Salud Industrial de Ponce	Covered at 100% up to $300 (Santurce) or up to $295 (Ponce)	Not covered as a package if service is provided by an out-of-network provider
	Routine physical, well-child care and Immunizations, gyn exam, and routine vision exam at a physician's office	Covered at 100% after a $10 copayment for the visit and 10% coinsurance for labs and X-rays Well-child visits limited to one visit per month during the first year of life.	Same as above**
	Lab and X-ray	10% coinsurance	Same as above**
Mental health/ substance abuse	Inpatient	Covered at 100% after a $150 copayment; for substance abuse and alcoholism conditions, one admission per contract year up to 45 days.	Same as above**
	Outpatient	Covered at 100% after a $10 copayment for substance abuse and alcoholism conditions, covered up to 20 visits per contract year.	80% of R&C after deductible if services are rendered outside PR; covered by reimbursement based on Triple-S established fee if services are rendered in PR by out of network Group therapy, collateral visit, and services for drug abuse and alcoholism will be reimbursed up to 50% after deductible, up to $30 per visit, limited to 50 visits per year.
Other professional care	Outpatient physical/ speech/ occupational therapy	Limited to 40 visits per calendar year	80% of R&C after deductible if services are rendered outside PR; covered by reimbursement based on Triple-S established fee if services are rendered in PR by out-of-network providers. 40-visit maximum.
	Chiropractor therapy	Not Covered	Limited to 20 visits per calendar year; subject to Triple S negotiated rate; Covered at 80% after deductible if services are rendered outside PR.

	Infertility	Copayments apply to covered services up to $24,000 lifetime medical maximum and a $7,500 prescription drug maximum. Contact Plan for specifics.
	Acupuncture	Covered at 80% based on Triple-S established fee ($20) after Major Medical annual deductible covered. Covered at 80% after deductible if services are rendered outside PR.
Key facts	PCP referral required for Specialist: No Blue Card Program for services outside of PR Domestic Partner Children coverage available: Yes Domestic Partner Coverage available: Yes Teleconsulta Program (Nurse Hotline) available 24 hours a day/ 7 days a week	

Mental health and substance abuse benefits

Triple-S PPO provides confidential mental health and substance abuse services through a network of counselors and specialized practitioners.

Precertification

Precertification helps ensure that you obtain the most appropriate care for your condition.

You are not required to obtain precertification for emergency hospitalization or other emergency services occurring outside Puerto Rico or the United States.

If you are using services outside the Triple-S PPO network in Puerto Rico, you will be reimbursed based on the contracted fees established with Triple-S participating providers.

For outpatient services and diagnostic testing

You should notify the health plan at least five business days before receiving any of the following services:

- Certain surgeries, such as upper eyelid surgery, breast reconstruction (other than following surgery for cancer), breast reduction, and any other surgery that could be related to cosmetic surgery. In the case of eyelid surgeries and surgeries related to cosmetic surgeries, a second opinion is required
- Out-of-network care;
- Specialist-to-specialist referrals; and
- Rehabilitation care.

Additional medical plan information

Prescription drugs

When you enroll in the Triple-S PPO, you have prescription drug coverage in the Citigroup Prescription Drug Program, administered by Caremark.

Caremark offers two ways to purchase prescription drugs:

- A network of retail pharmacies at which you can obtain prescription drugs for your immediate short-term needs, for example, an antibiotic to treat an infection.
- The Caremark Mail Service Pharmacy through which you may save money by having your maintenance drugs delivered by mail. Through the Caremark Mail Service Pharmacy, you can buy up to a 90-day supply of your medication. You will make one copayment for each prescription or refill for less than what you would pay to purchase the same amount at a retail network pharmacy.

Retail network pharmacies

Caremark has a network of retail pharmacies throughout Puerto Rico and the United States where you can obtain prescription drugs.

To find out whether a pharmacy participates in the Caremark network:
- Ask your pharmacist or
- Visit http://www.caremark.com and use the online pharmacy locator.

To have your prescription filled at a network pharmacy, present your prescription drug ID card. You will be charged the appropriate copayment based on whether your pharmacy participates in the primary network and your prescription is for a generic or brand-name drug.

The copayment structure is outlined below. Acute drugs are limited to a 15-day supply; maintenance drugs are limited to a 30-day supply. You will never pay more than the cost of the drug.

CITIGROUP PRESCRIPTION DRUG PROGRAM		
	Retail	Caremark Mail Service Pharmacy (90-day supply)
Copayment/coinsurance for up to a 15-day supply (acute drugs) or 30-day supply (maintenance drugs) at a retail primary network pharmacy		
• Generic drug[1]	$2 copayment	$6 copayment
• Brand name drug	20% coinsurance with a $4 minimum	$12 copayment
Benefits at a pharmacy outside the primary network		
• Generic drug[1]	10% coinsurance with a $5 minimum	N/A
• Brand name drug	20% coinsurance with a $10 minimum	

[1] The use of generic equivalents whenever possible is more cost-effective. If the physician allows a brand to be substituted for a generic, and you choose to take the brand drug, you will be required to pay the difference in price between the generic and brand drugs. For example, if the generic product has a

maximum allowable cost of $10, and you choose a branded product that costs $50, you will be charged a differential cost of $40, plus your generic copayment.

Managed drug limitations

Some medications, such as migraine agents and proton pump inhibitors, will be limited under clinical guidelines to a certain quantity within a given time frame.

Acute drugs are covered up to a 15-day supply at a network retail pharmacy**.**

The guidelines for use and quantity were developed by doctors and pharmacists based on accepted medical practices, Food and Drug Administration (FDA) guidelines, the recommendations of the drug manufacturer, and the cost-effective use of medicines.

In some cases, the quantity of your medication may require approval before it can be dispensed, if this is the case, your pharmacist can call Caremark at a special toll-free number that will be identified to the pharmacy at the time it processes the claim. You also can ask your doctor to call Caremark directly.

If you or your pharmacy calls Caremark, Caremark will need to contact your doctor. This typically takes one to two business days. Once your doctor provides the required information, Caremark will review your case based on clinical criteria and the information from your doctor. Once the review is completed, Caremark will advise your doctor and pharmacist of the decision.

If your medication or the requested quantity is not approved for coverage under the Citigroup Prescription Drug Program, you will be responsible for paying the full cost of the drug.

Caremark Mail Service Program

For prescription drugs you take over an extended period of time, such as blood pressure medication, insulin, or contraceptives, you may want to use the Caremark Mail Service Program to save on the cost of the drug.

Through the Caremark Mail Service Pharmacy, you can buy up to a 90-day supply of medication for one copayment per prescription or refill for the same or less than what you would pay to purchase the same amount at a retail network pharmacy with the convenience of having the medication delivered to your home.

With the Caremark Mail Service Pharmacy:

- Your medications are dispensed by one of the Caremark home delivery pharmacies and delivered to your home.
- Medications are shipped by standard delivery at no additional cost to you. Overnight or second-day shipping is available for an added charge.
- You can order and track your prescriptions online at www.caremark.com, or you can call Caremark and order your refill by telephone.
- Registered pharmacists are available 24 hours a day for consultations.

How to use the Caremark Mail Service Pharmacy
1. Ask your doctor to write two prescriptions:
    - One for a short-term supply (e.g., 30 days) to be filled immediately at a participating drug store.
    - One for up to 90 days with as many as three refills (if appropriate) to mail to Caremark Mail Service.

2. Complete the Caremark Mail Service order form available online at www.caremark.com or in your HR department. An incomplete form can cause delay in processing.

3. Mail your order form, along with your prescription and payment, in the Caremark Mail Service envelope. Caremark Mail Service accepts VISA, MasterCard, Discover, or American Express. You also can pay by check or money order. Do not send cash.

4. Allow 10-14 days from the day you mail your order for the delivery of your medication.

Refills: The information included with your order will show the date that you can request a refill and the number of refills remaining. You may order your refills online at www.caremark.com or by calling the toll-free number on your prescription label.

Specialty Pharmacy Services

Caremark offers a Specialty Pharmacy Program to dispense oral and injectable specialty medications for the treatment of chronic diseases, including but not limited to, multiple sclerosis, cancer, rheumatoid arthritis, Crohn's disease, and asthma.

Caremark Specialty Pharmacy offers to you additional advantages such as:
- No delivery charges (some restrictions may apply);
- Express delivery and;
- Access to pharmacist and other health experts 24 hours/seven days a week.

Procedure

All new specialty drug prescriptions should be dispensed by the Caremark Specialty Pharmacy and can be delivered to your home, office, or doctor's address.

To start the enrollment process with the Caremark specialty pharmacy, call 1-877-417-7154. Specialty help desk representatives will assist you. Spanish-speaking representatives are available.

Note: Specialty Drugs are subject to the Citigroup Prescription Drug Program coverage.

For information about Caremark Specialty Pharmacy services, and to find out if your prescription is for a specialty drug, call CaremarkConnect at 1-800-237-2767.

Dental

Citigroup offers two dental options: Basic and Comprehensive.

Both dental plans are administered by Triple-S. You can enroll in dental coverage even if you do not enroll in medical coverage. You can enroll in coverage for yourself and/or your eligible dependents in the same four coverage categories available for medical coverage. See "Coverage categories" on page 14.

DENTAL PLAN FEATURES		
	Basic Dental	**Comprehensive Dental**
Preventive and diagnostic services	100% paid	100% paid
Basic services	100% paid	100% paid
Endodontic services	100% paid	100% paid
Amalgam, silicate acrylic, synthetic porcelain filling restorations to diseased or fractured teeth	100% paid; 30% coinsurance for composite filing restoration	100% paid; 30% coinsurance for composite filing restoration
Space retainers	Not covered	50% coinsurance
Prosthodontic services, subject to precertification	Not covered	50% coinsurance; maximum benefit $800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Periodontal services	Not covered	$50 copayment and 50% coinsurance; maximum benefit $800 per participant per year (combined maximum for both prosthodontic and periodontal services)
Orthodontia	Not covered	$50 copayment and 50% coinsurance $3000 lifetime orthodontia limit
Implants	Not covered	50% no maximum

Basic Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filing restoration is covered at 70% of contracted fees.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

Comprehensive Dental

- Preventive and diagnostic services are covered at 100% of contracted fees.
- Basic and endodontic services are covered at 100% of contracted fees.
- Amalgam, silicate acrylic, and synthetic porcelain filling restorations to diseased or fractured teeth are covered at 100% of contracted fees. Composite filing restoration is covered at 70% of contracted fees.
- Space retainers are covered at 50% of contracted fees.
- Prosthodontic services are covered at 50% of contracted fees, subject to precertification and the maximum noted below.
- Periodontal services are covered at 50% of contracted fees after a $50 copayment, subject to the maximum noted below.
- The annual benefit maximum for prosthodontic and periodontal services combined is $800 per participant.
- Orthodontia is covered for all participants at 50% coinsurance after a $50 copayment with a $3,000 lifetime maximum per covered person.
- You or your dentist must submit a claim to be reimbursed for covered expenses.

Vision

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

You are eligible for an eye examination and one pair of eyeglasses (frame and lenses) or contact lenses, in lieu of eyeglasses, each calendar year. Additional features include services for low vision and a $225 benefit for medically necessary contact lenses purchased at a network or out-of-network provider with prior approval from Davis Vision.

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

Vision features

You will receive a different level of benefits depending on whether you use network or out-of-network providers.

Network benefits

- Examination: One eye examination, including dilation when professionally indicated, each calendar year covered at 100%;
- Frame and spectacle lenses: One pair of eyeglasses each year from the Davis Vision “Collection” covered at 100%; or
- A $61 wholesale allowance toward the cost of any non-“Collection” frame or an equivalent retail allowance at a retail chain, for example, a $150 allowance at a J.C. Penney Optical location. Spectacle lenses will be covered at 100% with any non-Collection frame; or

- Contact lenses in lieu of eyeglasses: Plan formulary contact lenses; One pair of soft standard daily-wear, or four boxes of disposable, or two boxes of planned replacement contact lenses, fitting, and follow-up care each calendar year covered at 100%; or
- If you choose contact lenses that are not covered under the Plan formulary, you will receive a maximum credit of $130 toward other lenses, plus 15% off overages (additional discount not applicable at Wal-Mart locations). The $130 credit is applied toward non-plan contacts, fitting, and follow-up);
- 20% discount on additional pairs of glasses at most network providers.

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

Out-of-network benefits

If you receive services outside the Davis Vision provider network, the Plan will reimburse you up to:

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

Definition of medical necessity

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

Contact lenses may be determined to be medically necessary in the treatment of keratoconus, anisometropia corneal disorders, pathological myopia, aniseikonia post-traumatic disorders, aphakia, aniridia, and irregular astigmatism. Coverage for medically necessary contact lenses will be provided after review and approval of Davis Vision.

Low vision

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

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

- Low-vision evaluation: One comprehensive exam every five years with a maximum charge of $300; sometimes called a functional vision assessment, this exam can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast, and lighting requirements for optimum vision.

- Maximum low-vision aid: Aids such as high-power spectacles, magnifiers, and telescopes, are covered at a maximum of $600 per aid with a lifetime maximum of $1,200. These devices are used to improve the levels of sight, reduce problems of glare, or increase contrast perception based on the individual's visual goals.
- Follow-up care: four visits in any five-year period with a maximum charge of $100 per visit.

LASIK

Davis Vision offers you the opportunity to receive $100 off each eye for laser vision correction, known as LASIK, at any laser facility of your choice in Puerto Rico. You will need to submit a claim form to be reimbursed. For more information about LASIK, call Davis Vision at 1-877-923-2847 or visit www.davisvision.com.

Health care ID cards

If you enroll in the Triple-S medical plan or a dental plan for the first time, you will receive your ID cards within three weeks of enrolling. You will receive two separate ID cards: a medical/ dental card from Triple-S and a prescription drug card from Caremark.

If you are enrolled in 2008 medical coverage and need to use a medical provider (doctor or hospital) in 2008 *before* you receive your ID card, show your confirmation statement or default statement along with the Triple-S group number (1-03450) to your provider. Call Triple-S at 787-774-6098 or 787-749-4777 to request coverage certification or a duplicate ID card.

Note: All ID cards are mailed to the Citigroup employee. If you have a student dependent living away from home, you will need to send that dependent his or her card. Cards are required to obtain services.

Disability

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

STD

The STD benefit is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Claims administrator before you can receive a benefit.

STD pays 100% or 60% of base salary (not total compensation) during an approved disability of up to 13 weeks based on your years of service. For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citigroup as an employee. You are credited with service from your hire date, or if you have had one or more breaks in service, from your adjusted service date. You will have a year of service for this purpose for each 12 months of service counting any part of a month in which you provided service. Service before a break in service will be allowed (or not) under rules similar to the Citigroup Pension Plan credited service rules, such as not counting service prior to five consecutive one-year breaks in service. In no event will the time between your periods of Citigroup service be counted.

STD schedule of benefits (benefits-eligible salaried employees)			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of base salary**
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

For Financial Advisors, Financial Advisor Associates, and Investment Associates Global Wealth Management and Account Executives in Citi Markets & Banking and the following schedule of benefits applies:

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

Pregnancy leave **For benefits-eligible salaried employees**			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of benefit**
Less than 1 month	8	0	8
1 month to less than 1 year	8	5	13
1 year or more	13	0	13

Pregnancy leave **For benefits-eligible commission-paid Account Executives and Financial Advisors**				
Years of service	**Minimum benefit (% of total compensation)**	**Plus additional benefit**	**Maximum benefit (% of total compensation)**	**Total weeks of benefit**
Less than 1 month	70%	Commissions	100%	8
1 month to less than 1 year	70%	Commissions	100%	13
1 year or more	80%	Commissions	100%	13

For employees paid on commission working in the Global Consumer Group: You will receive STD benefits based on a **phantom** salary as determined by your business (and not based on total compensation). If any commissions are generated while you are on an STD leave, they will be paid in addition to the STD benefit based on your length of service.

If you are a Smith Barney Business Analyst paid a monthly commission: You will receive STD benefits based on a recoverable draw against commissions.

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

When STD benefits are payable
STD benefits are payable if you incur a total disability while actively employed. A "total disability" is defined as a serious health condition, pregnancy, or injury that results

in your inability to perform the essential duties of your regular occupation for more than seven consecutive calendar days. If you remain totally disabled and are unable to work on the eighth calendar day, STD benefits — if approved — will begin on the eighth day of disability and will be paid retroactive to the first day of disability.

You are not considered to have a disability if your illness, injury, or pregnancy only prevents you from commuting to and from work. To qualify for STD benefits, you must be receiving appropriate care and treatment on a continuing basis from a licensed health care provider. You cannot qualify for STD benefits if you return to work on a part-time basis.

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

Long-Term Disability (LTD)

LTD coverage is offered to replace 60% of your total compensation as of the first day of your approved disability when your disability continues for more than 13 weeks. For purposes of calculating your LTD benefit, total compensation is limited to a maximum of $500,000.

Citigroup provides free LTD coverage to employees whose total compensation is less than or equal to $50,000.99, while employees with total compensation of $50,001 and above are required to make contributions for their coverage. The cost of LTD coverage is shown on the Citigroup Benefits Web Site and your Personal Enrollment Worksheet.

If you have been enrolled in the Plan for one year and leave Citigroup (other than to retire, which could occur if you terminate employment after attaining age 55 with at least five years of service or after attaining age 50 with 10 years of service), you can convert your Citigroup LTD coverage under the group policy to an individual policy within 31 days after your employment ends. To obtain a conversion form, call ConnectOne at 1-800-881-3938. From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative. The maximum benefit of this individual policy is $3,000 per month.

Unless you are already financially independent, you should think of LTD protection as an essential element of your personal financial plan since LTD coverage protects you in the event your ability to work is impaired by an accident or sickness.

You do not have to enroll in Citigroup LTD coverage. However, if you decide to enroll in LTD coverage at any time other than when first eligible (first 31 days after date of hire or during annual enrollment for the plan year after your total compensation exceeds $50,000.99) or as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health. In addition, the Plan will not cover any disability caused by, contributed to, or resulting from a pre-existing condition until you have been enrolled in the Plan for 12 consecutive months.

A pre-existing condition is an injury, sickness, or pregnancy for which — in the three months before the effective date of coverage — you received medical treatment, consultation, care, or

services; took prescription medications or had medications prescribed; or had symptoms that would cause a reasonably prudent person to seek diagnosis, care, or treatment.

IF YOUR TOTAL COMPENSATION IS:	
$50,000.99[1] or less	Citigroup provides LTD coverage at no cost to you
From $50,001 to $500,000	You will pay for coverage with after-tax dollars

[1] If your total compensation increases above $50,000.99 during the year and you want LTD coverage for the following year, you must enroll during annual enrollment. Otherwise, you won't have any LTD coverage beginning the first of the following year. You will not be required to provide evidence of good health to enroll at this time.

You may be eligible to receive LTD benefits after 13 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). See the schedule immediately following.

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

When LTD benefits are payable

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

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

If you qualify for STD benefits, return to work, and then, within a 30-day period, you're unable to work as a result of the same or a related total disability, your absence will be processed as a recurrent claim and you will be eligible to receive the balance of your STD benefits. If you

continue to be disabled and satisfy the 91-day waiting period, LTD benefits will begin once you are approved.

The receipt of STD and LTD benefits is subject to the terms and conditions of the applicable Plan. For related benefit offsets, exclusion, and limitations, see the Plan document and the insurance contract. This section is not intended to be a substitute for the actual Plan documents.

To review the Disability Plan document, visit **www.benefitsbookonline.com**. If you do not have access to this Web site, you can request a copy at no cost to you by speaking with a Benefits Service Center representative. Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for the Benefits Service Center.

Life insurance benefits

Basic Life/AD&D insurance

Citigroup provides Basic Life insurance (through MetLife) and Accidental Death and Dismemberment (AD&D) insurance (through CIGNA) at no cost to you. AD&D pays a benefit if you are dismembered or die as a result of an accidental injury.

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

Since Citigroup pays the full cost of your Basic Life insurance, you must pay taxes on the value of the coverage above $50,000.The remaining value of the life insurance is subject to tax as "imputed income," which is shown on your pay statement and Form W-2 for the year in which coverage was effective. This is not a deduction but an amount added to your taxable pay. Imputed income is based on the amount of Basic Life insurance coverage above $50,000.

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

Basic Life accelerated benefits option

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

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

If you leave Citigroup, you can convert your Basic Life/AD&D coverage to an individual policy by contacting MetLife within 31 days after your employment with Citigroup is terminated.

Optional GUL/Supplemental AD&D insurance

Coverage for employees

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

If you are enrolling outside of your initial eligibility period (31 days from your date of hire), as a result of a qualified change in status, or for an amount greater than three times your compensation or $1.5 million, you must provide evidence of good health and be actively at work before the coverage will be effective.

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.

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

If you leave Citigroup you can continue coverage. MetLife will bill you directly at a higher rate than the Citigroup group rate. The rate will become effective in the month following your termination of employment.

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

Optional GUL accelerated benefits option

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

Under the ABO, you may receive up to 50% of your GUL insurance amount, not to exceed $250,000, less any applicable expense charges. The accelerated benefit will be paid in a 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 examination 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 $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 Optional GUL/Supplemental AD&D coverage, you can participate in the CAF. The CAF allows you to save money that earns a competitive rate of interest on a tax-deferred basis. Contributions are deducted from your pay each pay period. The minimum contribution is $10 a month or $120 a year.

You will see your minimum and maximum contributions on the Citigroup Benefits Web Site and your Personal Enrollment Worksheet. If the premium that you pay by virtue of this election exceeds the actual limits of your certificate, based on the actual historical activity within your certificate, MetLife will contact you directly regarding a refund. You can change the amount of your contribution at any time. **Note:** A decrease in coverage amounts could affect your CAF contributions.

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

Coverage for your spouse/domestic partner

You can enroll in Optional GUL insurance coverage for your spouse/domestic partner in increments of $10,000 to a maximum of $100,000. You do not need to buy Optional GUL/Supplemental AD&D for yourself to elect coverage for your spouse/domestic partner.

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

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

The cost of coverage is based on the amount of coverage you elect, your spouse's/domestic partner's age, and whether he/she has used tobacco products in the past 12 months.

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

You also can open a Cash Accumulation Fund in your spouse's/domestic partner's name.

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

Coverage for your children

If you have enrolled in Optional GUL/Supplemental AD&D coverage for yourself or your spouse/domestic partner, you can enroll for life/AD&D insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. *A child must be at least 14 days old to be covered.*

When you enroll in life/AD&D coverage for your child, all of your eligible children are covered. **Note:** If you are enrolled in child coverage and have or adopt another child, you must report your child's birth or adoption to the Benefits Service Center so the new child can be covered.

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

Business Travel Accident insurance

Business Travel Accident (BTA) provides accident insurance only and pays benefits for bodily injury and/or death; it *does not* provide coverage for sickness. Coverage is provided by AIG.

All regular full-time and part-time employees have BTA coverage equal to five times total compensation to a maximum benefit of $2 million. Your spouse/domestic partner, and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

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

BTA benefits are paid in the event of death, dismemberment, paralysis, and loss of speech and/or hearing while traveling on an approved trip made on behalf of the Company. Certain covered losses are subject to limitations. Depending on the nature of your loss, you may be entitled to recover less than your total coverage amount. If you suffer more than one loss in an accident, you will be paid only for the loss that provides the largest benefit. Each aircraft accident is subject to a maximum benefit limit, regardless of the number of covered persons who incur a loss or the severity of the loss.

When you leave Citigroup, you can convert your BTA coverage to an individual accidental death and dismemberment policy if you have not attained the age of 70 and you submit an application and appropriate premium within 31 days after your termination of employment. The coverage under the individual policy will not be less than $25,000 or more than the greater of your employee coverage and $500,000.

Your BTA beneficiary, the person or persons designated to receive any benefit payable at your death, is the same beneficiary for your Basic Life insurance .

Long-Term Care (LTC) insurance

You can purchase LTC coverage for yourself and eligible members of your family at any time.

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

- Your spouse or domestic partner;
- Your parents or your parents-in-law;
- Your adult children or the adult children of your spouse or domestic partner*; and
- Spouses of your adult children.

Family members must be 18 or older.

If you are a new hire and enroll during your initial benefits enrollment: You will not have to provide evidence of good health.

If you enroll at any other time: You must provide evidence of good health acceptable to John Hancock.

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

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

Your family members can complete an application form and must provide evidence of good health acceptable to John Hancock before coverage will be approved. Family members, other than spouses/domestic partners, will be billed directly. Coverage will be effective the first of the month after their application is approved, provided they are not disabled on that date. If they are disabled on that date, coverage will take effect the first of the month after their disability ends, provided they are still eligible.

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

Family members who visit the Web site or call to obtain information should provide your name as the Citigroup employee.

Enrolling in LTC coverage

Enrolling in LTC coverage will be different from enrolling in other Citigroup health and welfare benefits. You will enroll in LTC coverage by submitting an enrollment form to John Hancock or clicking on a link from the Citi Benefits Web Site. Eligible family members must complete an application form.

When LTC benefits are payable

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

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

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

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

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

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

Benefits and services covered

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

Choosing a level of coverage

From the six options in the table below, you must choose a daily maximum benefit (DMB) from $115 to $405 a day. The DMB is the most the Plan may pay for all covered services received on any day. Each DMB has a corresponding lifetime maximum benefit (LMB), which is the total

amount payable for covered LTC services while you are insured for other than the stay-at-home benefit. Informal care also is subject to a calendar year maximum.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$ 290	$345	$405
Alternate care facility DMB	$115	$175	$230	$ 290	$345	$405
Community-based professional care DMB[1]	$86.25	$131.25	$ 172.50	$217.50	$258.75	$303.75
Informal care DMB	$ 28.75	$ 43.75	$ 57.50	$72.50	$ 86.25	$101.25
Informal care calendar year maximum[2,]	$ 862.50	$1,312.50	$1,725	$2,175	$ 2,587.50	$ 3,037.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$ 209,875	$ 319,375	$419,750	$529,250	$ 629,625	$ 739,125
Stay-at-home lifetime maximum	$ 3,450	$ 5,250	$6,900	$ 8,700	$ 10,350	$ 12,150

[1] This includes adult day care and the following services provided in your home: home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

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

Stay-at-home benefit

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

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

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

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

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

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

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

The contingent non-forfeiture benefit can be exercised only in the event of a substantial premium increase. A substantial premium increase would range from 10% at issue-age 90 or older to 200% at issue-age 29 or younger as detailed in the certificate that you will receive if you are approved for coverage. The contingent non-forfeiture benefit allows you to stop paying premiums and keep a reduced level of coverage.

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

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

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

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

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

The LMB will be increased in proportion to the increase in the nursing home DMB. An inflation adjustment will not be available if you are issue-age 85 or older or if you have met the benefit

eligibility requirements under the policy in the six months prior to the increase effective date or if your coverage is in reduced paid-up status.

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

Additional features

Return of premium at death benefit

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

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

Waiver of premium

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

Portability

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

Bed reservation benefit

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

Alternate plan of care

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

Restoration of benefits

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

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

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

Coordination of benefits and exclusions

To prevent duplication of benefits, the Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the Plan when benefits are payable under another plan.

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

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

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

For more information

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

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

Your family members who call or visit the Web site should provide your name as the Citigroup employee.

Employee Assistance Program (EAP)

Citi's EAP provides confidential assessment and referrals to mental health and substance abuse services through a network of counselors. Additionally, the EAP provides an online library of thousands of articles, self assessments, links, and related resources.

When you or an immediate family member calls the EAP at the toll-free number you will speak with an intake counselor who will listen to your concern and refer you to an appropriate EAP

provider in your community. You may attend up to six free sessions. If you require additional counseling, you will be responsible for any fees. You should check with your Triple S health plan provider to find out how additional treatment will be reimbursed. In an emergency, the intake counselor also will provide immediate assistance and, if necessary, arrange for treatment at an appropriate facility

EAP services are provided on a per-issue basis and are not restricted solely to six sessions per person annually.

Glossary

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

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

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): A U.S. law mandating that anyone belonging to a group health insurance plan must be allowed to purchase health insurance within an interval of time beginning when the previous coverage is lost. The law protects employees — especially those with long-term health conditions who may be reluctant to leave jobs because they are afraid that pre-existing condition clauses will limit coverage of any such conditions under a new insurance plan — from losing health insurance due to a change in employment status.

Medically necessary: A service or supply is 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.

Precertification: A requirement that a participant call his or her health plan to coordinate any inpatient surgery, hospitalization, and certain outpatient diagnostic/surgical procedures. If you do not call your health plan in advance of certain procedures, your benefits will be subject to a non-notification penalty each time your plan is not notified. Notification helps ensure that you obtain the most appropriate care for your condition in the most appropriate setting. Call your plan for more information.

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.

QMCSO: Qualified Medical Child Support Order.

Wellness services: Charges for routine care examinations 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.

Legal and administrative information

When coverage ends

Your coverage under the Citigroup Medical Plan, Dental Plan, and Vision Plan automatically will terminate on the earliest of the following dates:

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

Basic Life insurance, Short-Term Disability, and Long-Term Disability coverage end on the date your employment is terminated. Optional GUL insurance coverage ends on the last day of the month in which your employment is terminated.

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

- Midnight of the last day of the month in which your coverage is terminated, except in the case of your death in which case coverage will continue for six months;
- The date you elect to terminate your eligible dependent's coverage;
- The last day for which the necessary contributions are made;
- The date the eligible dependent ceases to be eligible for coverage; coverage will remain in effect through December 31 of the year in which the child reaches the maximum age or is no longer a full-time student; coverage will remain in effect through the end of the month in which the child gets married or obtains a full-time job;
- The date the eligible dependent is covered as an employee under the Plan;
- The date the eligible dependent is covered as the dependent of another employee under the Plan;
- The date the eligible dependent enters the armed forces of any country or international organization; or
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" on page 63.

Coverage when you retire

You could be eligible for retiree health care coverage if you are at least age 55 with at least five years of service when you leave Citigroup. In addition, effective for terminations of employment on or after March 1, 2007, you could be eligible for retiree health care coverage if you are at least age 50 with at least 10 years of service when you leave Citigroup. For more information on eligibility for this coverage, contact the Benefits Service Center. You will be required to contribute to the cost of coverage.

Coverage for surviving dependents

When an active employee dies, if the surviving spouse and/or dependent children were enrolled in active coverage at the time of the employee's death, then these covered individuals will be eligible to continue health care coverage for six months at no cost.

If the employee was not eligible for retiree health care coverage at the time of death: Medical and dental coverage will continue for the covered individuals for six months at no cost. ADP, Citigroup's COBRA administrator, will send a COBRA notification package. To receive this six-month period of free medical and dental coverage, eligible covered survivors must elect COBRA continuation by signing and returning the election form to ADP.

If the employee was eligible for retiree health care coverage at the time of death: At the end of this free six-month period, following the procedure noted above, covered individuals can either continue COBRA coverage or elect retiree health care coverage. The retiree health care coverage will be provided on the same terms as coverage provided to a retired employee.

Coverage if you become disabled

If you are disabled, you and your eligible dependents may continue medical, dental, and vision care coverage for up to 13 weeks, as long as you make the active employee contributions.

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

Medical 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 medical coverage by making the same contributions as active employees, based on your years of service as shown below. (After 52 weeks of disability, your employment will be terminated.)

LENGTH OF RECOGNIZED YEARS OF SERVICE AT THE TIME YOUR LTD IS APPROVED	MEDICAL CONTINUATION PERIOD AFTER WEEK 52 (THE TERMINATION OF YOUR EMPLOYMENT)
Less than 2 years	6 months
2 years to less than 5 years	Equal to your length of service
5 years or more	As long as you are disabled or have not reached the maximum age limit to receive LTD benefits

Your disability claims administrator will medically manage your disability if you are a totally disabled employee who has been denied LTD due to a pre-existing condition, did not enroll in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule.

If the claims administrator determines that you are totally disabled, medical coverage will continue at the active employee rate for the lesser of a length of time based on your years of service (see chart above) or the length of your disability.

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.

Dental coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. You may then continue coverage under COBRA.

Vision coverage will continue for the 13-week period of STD as long as you make the active employee contributions. You may then continue coverage through Davis Vision.

Basic Life/Accidental Death and Dismemberment (AD&D) insurance and Optional Group Universal Life (GUL)/AD&D insurance coverage stops after 52 weeks, but you can convert your Basic Life/AD&D coverage to an individual policy, and continue your GUL coverage at a higher rate by calling MetLife as instructed on page 85.

Coverage if you take a leave of absence

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

Continuing coverage during an FMLA leave

The Family and Medical Leave Act (FMLA) entitles eligible employees to take leave each year for their own serious illness; the birth or adoption of a child; or to care for a spouse/domestic partner, child, or parent who has a serious health condition.

If you are eligible for FMLA, you may take up to a total of 13 weeks of leave each year, except where state law mandates differently.

If you take an unpaid leave of absence that qualifies under FMLA, you may continue medical, dental, and vision coverage for yourself and your dependents as long as you continue to contribute your share of the cost of coverage during the leave. You will be billed directly.

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

If you do not return to work at the end of your FMLA leave, you will be entitled to enroll in COBRA to continue your medical, dental, and vision coverage.

If your employment is terminated while you are on an FMLA leave, you also may be eligible to continue your coverage under COBRA.

Continuing coverage during a military leave

The Citigroup Paid Military Leave of Absence Policy was last updated March 11, 2006. For the latest copy of the policy, visit Citigroup.net. From the home page, use the search function and enter "military leave." Then click on the most current policy.

If you take a military leave, whether for active duty or for training, you are entitled to continue your health coverage in accordance with the terms and conditions of the Citigroup's Paid Military Leave of Absence Policy.

If you take a military leave of absence — whether for active duty or for training — you are entitled to continue your medical, dental, and vision coverage at active employee rates for the length of your leave. Employee contributions will be deducted automatically from your pay.

The start of a military leave is considered a qualified change in status. As a result, you may stop coverage under any of the health and welfare benefit plans in which you are enrolled or, if you have not previously done so, you may enroll in certain coverage.

You must contact the Benefits Service Center to enroll in or stop coverage. If you do not contact the Benefits Service Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave (unless coverage stops automatically when your leave ends).

You can participate in any annual enrollment periods that occur while you are on a military leave. If you are unable to make elections during annual enrollment, your elections will continue in effect until you return from your leave when you can make new elections for all health and welfare plans. If you elect to discontinue coverage while on leave, you will have the right to re-enroll when you return to work.

Call the Benefits Service Center, as instructed on page 85, or contact your HR representative for more information about a military leave.

Important Notice From Citigroup About Your Prescription Drug Coverage and Medicare

Citigroup has determined that prescription drug coverage provided through the Medical Plan is "creditable" under Medicare.

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citigroup medical plans.

This notice, required by Medicare to be delivered to Medicare-eligible individuals,[2] 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 at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

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 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

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

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 if you so choose. 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 November 15-December 31 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 because of your lost coverage. In addition, if you lose or decide to terminate your coverage under the Citigroup prescription drug plan; you will be eligible to join a Medicare prescription drug plan at that time under the SEP, as well. If, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium will increase at least 1% for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19% higher than what most other people pay for the same coverage. You must pay this higher premium percentage as long as you have Medicare coverage. In addition, you may have to wait until the next annual enrollment period to enroll.

For more information about Medicare

You can obtain more information about Medicare prescription drug plans from these sources:

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

Do you qualify for "extra help" from Medicare based on your income and resources? You can find Medicare's income level and asset guidelines at www.cms.hhs.gov/medicarereform/lir.asp or by calling 1-800-MEDICARE (1-800-633-4227). If you qualify for assistance, visit the Social Security Web site at www.socialsecurity.gov/ or call 1-800-772-1213 to request an application.

For more information about this notice

Call ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative.

For text telephone service, call the Telecommunications Relay Services at 1-866-280-2050. Then call ConnectOne at 1-800-881-3938 as instructed above.

NOTE: You will get this notice each year. You also will get it before the next period you can join a Medicare drug plan, and if this coverage through Citigroup changes. You also may request a copy.

Notice of HIPAA Privacy Practices

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

This notice also sets out Component Plans' legal obligations concerning your protected health information and describes your rights to access and control your protected health information. The Component Plans have all agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule.

For answers to your questions and for additional information. If you have any questions or want additional information about this notice, contact Citigroup as instructed on page 80. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed on page 81.

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 (i) that is created or received by a health care provider, health plan, insurance company, or health care clearinghouse; (ii) 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 (iii) 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 obligated to provide you with 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 that are included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule.

Payment. Component Plans will use or disclose your protected health information to fulfill their responsibilities for coverage and providing benefits as established under their governing documents. For example, Component Plans may disclose your protected health information when a provider requests information regarding 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 (i) to provide you with information about a disease management program; (ii) to respond to a customer service inquiry from you; (iii) in connection with fraud and abuse detection and compliance programs; or (iv) 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, and 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.

This also means that Component Plans 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 may also 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, by way of 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 for identifying a deceased person or determining 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 (information such as name, address, Social Security number, etc., that can identify you).

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 Restrictions" on page 53). 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.

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 on page 81.

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 on page 81. 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).

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 on page 81.

Your request must specify the alternative means or location for communication 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 for postage, if you request that copies be mailed to you. 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.

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 on page 81 and must set forth a reason(s) in support of 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 on page 81. 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, see the contact information on page 80.

Complaints

If you believe a Component Plan has violated your privacy rights, 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 on page 81. Component Plans will not penalize you for filing a complaint.

Changes to this notice

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

Effective date

This Notice of Privacy Practices became effective April 14, 2003.

Contact information

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

Citigroup Privacy Officer
c/o Corporate Benefits Department
125 Broad St., 8th Floor
New York, NY 10004.

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 Medical Plan • Citigroup Dental Plan • Citigroup Vision Plan	ConnectOne at 1-800-881-3938. From the ConnectOne main menu, choose the "health and welfare benefits" option and then follow the prompts to speak with a representative. **From outside the United States:** Call 469-220-9600 **For TTY telephone service:** • Call 1-866-280-2050 • For the Telecommunications Relay Services, call 1-866-280-2050. Then call ConnectOne at 1-800-881-3938.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that most employers sponsoring group health plans offer to employees and eligible dependents the opportunity for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the plan would otherwise end (called "qualifying events").

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

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

You must pay the entire contribution (employer and employee contribution) plus a 2% administrative fee for your continuation coverage. A grace period of at least 30 days applies to the payment of the regularly scheduled contribution. A 45-day grace period applies for your first payment.

Who is covered

You have a right to choose this continuation coverage if:

- You are enrolled in Citigroup medical, dental, or vision coverage and
- You lose your group health coverage because of a reduction in your hours of employment or the termination of your employment for reasons other than gross misconduct on your part.

If you terminate employment following a leave of absence qualifying under the Family and Medical Leave act (FMLA), the qualifying event that will trigger continuation coverage will be deemed to occur on the earlier of (a) the date that you indicate you will not be returning to work following the leave or you don't return to work after the leave or (b) the last day of the FMLA leave period.

If you are the spouse (or the domestic partner) of an employee and are covered by Citigroup-sponsored Plans on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself if you lose coverage under a Citigroup-sponsored group health Plan for any of the following four reasons:

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

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

1. The death of the employee;
2. The termination of the employee's employment (for reasons other than the employee's gross misconduct) or a reduction in the employee's hours of employment;
3. The employee's divorce or legal separation;
4. The employee's entitlement to Medicare; or
5. You cease to be a "dependent child" under the Citigroup-sponsored medical, dental, or vision 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 Citigroup of the birth or adoption.

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

Separate elections

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

Electing COBRA

To elect or inquire about COBRA coverage, call ConnectOne at 1-800-881-3938. From the main menu, choose the "health benefits" option and follow the prompts for a Benefits Service Center representative.

Under the law, you must elect continuation coverage within 60 days from the date you would lose coverage because of one of the events described above, or, if later, 60 days after Citigroup 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, Citigroup is required to give you coverage that, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated employees or family members. This means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified, 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 and your family be afforded the opportunity to maintain continuation coverage for 18 months in the event that you lost group health coverage because of a termination of employment or reduction in hours. 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 losing eligibility as a dependent child, COBRA continuation coverage is available for up to 36 months.

Additional qualifying events (such as a 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 the initial qualifying event such as the loss of employment) may occur while the continuation coverage is in effect. If you lost coverage because of a termination of employment or a reduction in hours, these events can (but do not always) result in an extension of an 18-month continuation period to 36 months for your spouse and dependent children, but in no event will coverage last beyond 36 months from the date of the event that originally made a qualified beneficiary eligible to elect coverage. You must notify Citigroup if a second qualifying event occurs during your continuation coverage period.

When COBRA medical coverage ends, 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 to be disabled (for Social Security disability purposes) at any time during the first 60 days of continuation coverage.

This 11-month extension is available to all family members who are qualified beneficiaries due to termination or reduction in hours of employment, even those who are not disabled. To benefit from the extension, the qualified beneficiary must inform Citigroup within 60 days of the Social Security determination of disability and before the end of the original 18-month continuation coverage period. If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must inform Citigroup of this redetermination within 30 days of the date it was 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 is 36 months after the 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, dental, or vision care) 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 your continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any person who elected COBRA for any of the following five reasons:

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

HIPAA restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan, and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated.

However, if the other plan's pre-existing condition rule does not apply to you by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate your COBRA coverage.

COBRA and FMLA

A leave that qualified under the FMLA does not make you eligible for COBRA coverage. However, regardless of whether you lose coverage because of non-payment of premiums during an FMLA leave or you decide not to return to active employment, you are still eligible for COBRA on the last day of the FMLA leave. Your continuation coverage will begin on the earliest of the following:

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

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

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

Your duties

Under the law, the employee or a family member is responsible for notifying Citigroup of:

- A divorce or legal separation;
- Loss of a child's dependent status under the medical, dental, or vision plan;
- Additional qualifying events (such as a death, divorce, legal separation, or Medicare entitlement) that occurs during the employee's or family member's initial continuation coverage of 18 (or 29) months;
- A determination by the 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
- 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 Citigroup during this notice period, any individual(s) who loses coverage will *not* be offered the option to elect continuation coverage.

The notice must be in writing and must include the following information: The applicable Plan name, the identity of the covered employee and any qualified beneficiaries, a description of the qualifying event or disability determination, the date on which it occurred, and any related information customarily and consistently requested by the Plan's COBRA administrator.

If you are an active employee of any Citigroup business in Puerto Rico, mail this notice to:

Citigroup Benefits Service Center
P.O. Box 56710
Jacksonville, FL 32241-6710

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

Citigroup's duties

Qualified dependents will be notified of the right to elect continuation coverage automatically (without any action required by the employee or a family member) if any of the following events occurs that will result in a loss of coverage:

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

Cost of coverage

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

The cost of group health coverage periodically changes. If you elect continuation coverage, Citigroup will notify you of any changes in the cost. 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 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 30 days.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator at the address listed below. If your marital status has changed, or you, your spouse, or a dependent 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 listed below.

All notices and other communications regarding COBRA and the Citigroup Plans should be directed to:

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

You also may call the COBRA administrator at 1-800-422-7608.

Recovery provisions

Recovery provisions apply to the Citigroup Plans and are described in this section.

Refund of overpayments

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

In the case of a recovery from a source other than the Plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan that should have been made under another group plan. In that case, the Plan 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 Plan 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 which would otherwise be due under the Plan (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the covered person.

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

Reimbursement

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

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

If the covered person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the covered person has

received benefits from the Plan, the Plan must be reimbursed first. In other words, the covered person's recovery from a third party may not compensate the covered person fully for all 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 rights. 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 the Plan or any other disability or health plan maintained by Citigroup or its participating companies to the extent necessary to reimburse the 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; and
- Assigns to the Plan any benefits the covered person may have under any automobile policy or other coverage. The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits.
- The covered person will cooperate with the Plan and its agents and will:
  - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
  - Provide any relevant information; and
  - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

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

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

Subrogation

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

The Plan is subrogated to all the rights of the covered person against any party liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or

occupational illness (including any insurance carrier) to the extent of the value of the medical benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

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

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Planunder 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 Citigroup Health and Welfare Plans subject to 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 Administrators, as applicable. For more information about the Plan Administrator and Claims Administrators, see page 80.

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

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

Medical benefits claims

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

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.

Urgent care claim. An urgent care claim is a special type of preservice claim. A claim involving urgent care is any preservice claim for medical care or treatment with respect 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 make a determination of 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.

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.

Concurrent care claims. A concurrent care decision occurs where the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims: (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding initial medical benefit claims

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

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

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

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 timeframes 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. 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 timeframes, nothing prevents you from voluntarily agreeing to extend above timeframes. 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 timeframe, no less than 45 days, in which the necessary information must be provided. The timeframe for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of initial benefit decision by Plan

Written notification will be provided to you of an adverse decision on a claim, and 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; and
- 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 not later than three days after the oral notice.

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision) must by filed within 30 days of your receipt of the notification of the decision to reduce or terminate. Failure to comply with this important deadline may cause you to forfeit any rights to any further review of an adverse decision under these procedures or in court of law.

The appeal of a preservice claim 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 exigencies, but no later than 72 hours after receipt of the appeal.

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

The appeal of a decision to reduce or terminate and initially approved course of treatment (see the definition of concurrent care decision) 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 timeframe for a preservice, urgent care, or post-service claims described above, as appropriate to the request.

Notice of benefit determination on appeal

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

1. The specific reason or reasons for the denial of the appeal;

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

All other benefits claims

If your application to enroll in any of the health and welfare plans subject to ERISA is denied, you may file a claim with the Plans Administration Committee, which shall be decided in accordance with the timeframes set forth below. You may also file an appeal if the Plans Administration Committee denies your claim. To file an enrollment-related claim and for information on the claim review process, use the Health and Disability Benefits Eligibility Claims and Appeals Form available to you at no cost through the Benefits Service Center. Call the Benefits Service Center as instructed on page 85, and follow the instructions on the form and return the form to the Plans Administration Committee at the address on the form.

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

Notice of adverse benefit determinations

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

1. The specific reasons for the denial;
2. The specific reference to the Plan documentation that supports these reasons;
3. The additional information you must provide to perfect your claim and the reasons why that information is necessary; and
4. The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review; and

5. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request).

Appeals

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

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

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

The Claims Administrator will reach a determination regarding your appeal 60 days after its receipt (120 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 60 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date). In the case of a claim for disability benefits, the Claims Administrator will reach a determination regarding your appeal 45 days after its receipt (90 days if the Claims Administrator determines that special circumstances require an extension and, before the expiration of the initial 45 days, you are notified in writing of the circumstances warranting the extension and the anticipated determination date).

Notice of Benefit Determination on Appeal

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

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

ERISA information

As a participant in Citigroup Health and Welfare Plans that are 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 not cost to you upon request at the location of the Plan Administrator or other specified locations.

Upon written request to the Plan Administrator, you may obtain copies of documents governing the operations 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 may also receive a copy of the Plan's annual financial reports. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

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

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

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

- When you lose coverage under the Plan;

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

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

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plans review and reconsider your claim and provide you with copies of documents relating to the decision without charge. For more information see the "Claims and appeals" section on page 71.

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

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

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

Answers to your questions

If you have questions about the Plans, contact the Plan Administrator.

If you have any questions about this book 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 may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications' hotline of the Employee Benefits Security Administration or by visiting its Web site at www.dol.gov/ebsa/.

Administrative Information

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

Future of the Plans

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

Citigroup Inc. (or its affiliates, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy or program in whole or in part, at any time, for any reason, without prior notice, including the Plans described in this SPD.

In the event of the dissolution, merger, consolidation, or reorganization of Citigroup, the Plan will terminate unless the Plan is 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 and such determinations shall be binding on all parties.

The Plan Administrator has designated other organizations or persons to act out specific fiduciary responsibilities in administering the 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 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. 75 Holly Hill Lane Greenwich, CT 06830
EMPLOYER IDENTIFICATION NUMBER	52-1568099
PLAN ADMINISTRATOR	Plans Administration Committee of Citigroup Inc. 125 Broad St., 8th Floor New York, NY 10004 1-800-881-3938 (ConnectOne). From the main menu, choose the "health and welfare benefits" option and then follow the prompts for a Benefits Service Center representative. From outside the United States, call 469-220-9600. If you are hearing-impaired, call the National Relay Services at 1-866-280-2050. Then call ConnectOne at 1-800-881-3938..
PLAN NAMES AND NUMBERS	
Medical Plan Triple-S Prescription Drug Plan Caremark	Citigroup Health Benefit Plan, Group # 1-03450 Group #6569 Plan # 508
Dental Plan Triple-S	Citigroup Dental Benefit Plan, Group # 1-03450 Plan # 505
Vision Plan	Citigroup Vision Benefit Plan Plan # 533
Employee Assistance Program	Citigroup Employee Assistance Program, Plan # 521
Basic Life insurance/AD&D Optional GUL/Supplemental AD&D Business Travel Accident Insurance	Citigroup Life Insurance Benefits Plan, Plan #506 Citigroup Business Travel Accident Plan, Plan #510
Citigroup Long-Term Care Insurance	Citigroup Long-Term Care Insurance Plan, Plan #535

Short-Term Disability	Citigroup Disability Plan, Plan #530
Long-Term Disability	

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 their respective benefit Plan, namely, those provisions of the Plan document that apply to the participant and administered by that particular Claims Administrator.

PLAN NAMES AND NUMBERS

MEDICAL PLAN	
Preferred Provider Organization (PPO)	Triple-S PO BOX 363628 San Juan PR 00936-3628 (mailing address) 787-774-6098 or 787-749-4777
Prescription Drug Program (retail pharmacy)	Caremark 9501 E Shea Blvd, MC018 Scottsdale, AZ 85260 Montehiedra Office Center 9615 Ave. Los Romeros-Suite 515 San Juan, PR 00926-7038 1-800-390-6441
DENTAL PLAN	
Triple-S	Triple-S P.O. Box 363628 San Juan PR 00936-3628 787-774-6098 or 787-749-4777
VISION PLAN	
Davis Vision	159 Express St. Plainview, NY 11803 516-932-9500 1-800-DAVIS-2-U

LIFE INSURANCE

Basic Life	Metropolitan Life Insurance Co. One Madison Ave. New York, NY 10010 1-800-638-6420
Optional GUL(Group plan #96731)	Metropolitan Life Insurance Co. P.O. Box 3016 Utica, NY 13504 1-800-523-2894
AD&D and Supplemental AD&D	
Business Travel Accident Insurance	Life Insurance Company of North America 1601 Chestnut St. Philadelphia, PA 19192 215-761-1000
LONG-TERM CARE INSURANCE	AIG AIG Domestic Accident & Health Division National Union Fire Insurance Co. of Pittsburgh, PA 70 Pine Street New York, New York, 10270 1-800-551-0824
	John Hancock Life Insurance Co. Group Long-Term Care, B-6 200 Berkeley Street Boston, MA 02117 1-800-222-6814

PLAN INFORMATION

AGENT FOR SERVICE OF LEGAL PROCESS	Citigroup Inc. General Counsel 399 Park Ave., 3rd Floor New York, NY 10043

PLAN YEAR	January 1-December 31
FUNDING	
Medical Plan Dental Plan Vision Plan Employee Assistance Program	The Medical and Dental Plans are funded from the general assets of Citigroup and may be funded from a trust qualified under section 501(c)(9) of the Code on behalf of the Plans in accordance with the terms of their Plan documents. The Vision Plan is funded through an insurance contract. The Employee Assistance Program is funded from the general assets of Citigroup. The cost of Medical and Dental coverage is shared by Citigroup and the participant. The cost of the Vision Plan is provided by employee contributions. The Employee Assistance Program is provided by employer contributions.
Basic Life/AD&D Optional GUL/Supplemental AD&D Business Travel Accident Insurance	The Basic Life/AD&D, Optional GUL/Supplemental AD&D, are fully insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life/AD&D coverage is provided through employer contributions; Optional GUL/ Supplemental AD&D is provided through employee contributions. The BTA is funded by an insurance contract. BTA coverage is provided through employer contributions.
Disability Plan	STD benefits are paid from the general assets of the Company or a trust qualified under section 501(c)(9) of the Code. STD coverage is provided by Citigroup, and no employee contributions are required. LTD benefits are fully insured. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
Long-Term Care	LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions. Any refund, rebate, dividend adjustment, or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses.

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 rest with the Claims Administrators.

Telephone and Web site directory

You can contact many of the vendors through the "health and welfare benefits" option of ConnectOne.

Benefits Service Center Available by choosing the health benefits option of ConnectOne For plan information and to enroll, visit the Internet	 1-800-881-3938 469-220-9600(from outside the United States and Puerto Rico) 1-866-280-2050 (TTY) For the Telecommunications Relay Services, call 1-866-280-2050. Then call ConnectOne at 1-800-881-3938, **https://mybenefits.csplans.com**
Consolidated Omnibus Budget Reconciliation Act (COBRA)	 1-800-422-7608
Medical Triple-S **Dental** Triple-S	 787-774-6098 or 787-749-4777 www.ssspr.com
Life/Accidental Death and Dismemberment (AD&D) insurance Basic Life - Benefits Service Center; available by choosing the health benefits option of ConnectOne Optional Group Universal Life (GUL)/Supplemental AD&D insurance - MetLife	 1-800-881-3938 1-800-523-2894
Long-Term Care insurance John Hancock Life Insurance Co.	1-800-222-6814 **http://groupltc.jhancock.com** User name: groupltc Password: mybenefit
Disability/FMLA MetLife For Short-Term Disability (STD), Long-Term Disability (LTD), and Family and Medical Leave Act (FMLA) information To report a disability or FMLA leave, choose the "managed disability" option of ConnectOne You also can report a disability by calling MetLife directly	 1-800-881-3938 1-800-826-0547
Prescription Drug Program Caremark	 1-800-390-6441 www.caremark.com
Total Compensation Web site	www.totalcomponline.com
Vision Care Plan Davis Vision	 1-800-999-5431 www.davisvision.com

Employee Assistance Program **Harris Rothenberg**	1-800-952-1245 TTY: 800-256-1604 https://www.harrisrothenberg.com/loginc.html User ID: umbrella, password: group

This document is intended to provide a brief overview of your benefits. Citigroup reserves the right to change or to discontinue any or all of the benefits coverage or programs described here at any time with or without notice. No statement in this or any other document and no oral representation shall be construed as waiving this right. The Plan Administrator, except to the extent not delegated to the Claims Administrator, has the sole discretion to interpret all of the provisions contained here, including the discretion to interpret the terms of eligibility for any of the benefits provided. Any such interpretation may only be relied upon if in writing from the Plan Administrator. 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.