The Citigroup Disability Plan

Effective January 1, 2007

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About the Plan

Citi provides you with income in the event of your disability under the Citigroup Disability Plan (the "Plan"). There are two components of the Plan – the Citigroup Short Term Disability Plan (the "STD Plan") and the Citigroup Long Term Disability Plan (the "LTD Plan"). The Plan is sponsored by Citigroup Inc. ("Citigroup"). Prior to 2007, the STD Plan and the LTD Plan were separate plans, and they were merged to form the Plan effective January 1, 2007.

This document (the "Plan Document") describes the terms and conditions of your coverage under the STD Plan and the LTD Plan. Further details about your coverage under the LTD Plan can be obtained from the insurance certificate, which is also deemed to be part of the Plan. Should there be any discrepancy between the provisions outlined in the Plan Document and the related insurance certificate produced by the insurance company, the provisions of the insurance certificate shall prevail. The Plan is governed by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Plan is intended to comply with the requirements under ERISA.

As the Claims Administrator, MetLife is the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact relating to claims for benefits. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law. All other aspects of administration of the Plan are the responsibility of the Plans Administration Committee of Citigroup Inc.

If you are currently out of work for a disability that began prior to January 1, 2007 you are not covered under this document, but you may be eligible for benefits under the terms of prior disability plans.

If benefits are overpaid on your claim under either component of the Plan, you will be required to reimburse the applicable Plan within 60 days, or the Plan will have the right to reduce future benefits until reimbursement is made. The Plan also has the right to recover such overpayments from your estate.

Citigroup reserves the right to terminate or amend this plan at any time without notice.

Eligible Employees Covered by the Plan

Active full-time employees regularly scheduled to work 40 hours or more a week and active part-time employees regularly scheduled to work 20 hours or more a week, who work for a participating employer as defined below, for a regular semimonthly or monthly paycheck are eligible ("Eligible Employees") to participate in the Plan.

The Plan Sponsor is Citigroup and Eligible Employees of participating employers (the "Participating Employers") may participate in the Plan. The Participating Employers are all entities under common control of Citigroup in the U.S., pursuant to Sections 414(b), and (c) of the Internal Revenue Code of 1986 (the "Code"), as amended and participating employers in Puerto Rico, who employ employees in the following businesses:

- Global Consumer Group;
- Global Wealth Management;
- Citi Markets and Banking;
- Citi Alternative Investments; and
- Citi Corporate Center.

For purposes of determining whether you are an Eligible Employee, you are an active employee if you are working for your employer doing all the material duties of your occupation at your usual place of business or some other location that your employer's business requires you to be or absent from work solely due to vacation days, holiday, scheduled days off or paid approved leaves of absence not due to disability (excluding military leaves).

You are not an Eligible Employee and cannot participate in the Plan if:

- your compensation is not reported on a Form W-2 Wage and Tax Statement issued by a participating employer (except that residents of Puerto Rico and participants in the approved expatriate classification may be eligible employees without regard to this requirement);

- you are employed by a Citigroup subsidiary or affiliate that is not a participating employer;

- you are engaged under an agreement or a corporate policy that states you are not eligible to participate in the Plan;

- you are a non-resident alien performing services outside the United States; or

- you are classified by Citigroup as an independent contractor or consultant, or as being employed on a temporary basis.

Individuals who are employed by a Citigroup Inc. subsidiary outside the United States in an approved expatriate classification may be eligible for benefits under this Plan, in accordance with approved Citigroup expatriate policies.

If a court, regulatory body, administrative agency, or other entity having jurisdiction later decides that an individual who was not treated as an employee should have been considered an employee of Citigroup or a Participating Employer, or is otherwise entitled to receive a Form W-2 from Citigroup or a Participating Employer, he or she still will not be retroactively considered an Employee for purposes of the Plan (except prospectively if the individual otherwise meets the definition of an eligible employee).

Definition of Total Compensation

With regard to certain commissioned participants under the STD Plan and all participants under the LTD Plan, benefit amounts are based on the participant's total compensation as defined below ("Total Compensation") for the plan year in which an approved disability commenced.

With respect to the current plan year, Total Compensation consists of (a) the annual base pay as of July 1 of the calendar year which precedes the current plan year (the "Prior Year"); (b) any commissions paid during the calendar year which precedes the Prior Year; (c) any cash bonuses paid during the calendar year which precedes the Prior Year (excluding Annual Discretionary Incentive Awards); (d) any Annual Discretionary Incentive Award earned during the calendar year which precedes the Prior Year and that, during the Prior Year, is paid in cash or in the form of an equity award under the Capital Accumulation Program ("CAP") Basic Award, and, for employees with discretionary award packages valued at $500,000 and above, Supplemental CAP awards; and (e) any short term disability benefits paid in the calendar year preceding the Prior Year (for commission only employees), and as determined by Citigroup for subsequent years.

If you were hired or rehired on or after July 1 of the Prior Year, your Total Compensation is your annualized base pay as of your date of hire or rehire. Notwithstanding the foregoing, a new hire's definition of Totat Compensation shall include any guaranteed bonus awarded to the employee.

Notwithstanding the foregoing, the list of items that constitute Total Compensation under the Plan is exclusive, and shall not include any extraordinary payments, including but not limited to those related to settlements or forgivable loans, unless specifically set forth in the plan document or in an agreement or statement of policy approved or authorized by the Senior Human Resources Officer of Citigroup Inc. or his or her delegate.

If you are a Global Wealth Management Financial Advisor your Total Compensation is deemed to be $60,000 in your first year of employment. 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 Wage and Tax Statement to Human Resources within 30 days after your hire date.

If you became eligible to participate in the Citigroup plans as a result of an acquisition in 2007, the definition of Total Compensation for purposes of benefits may differ from the definition provided above. For acquisition-related definitions of Total Compensation, see Appendix A of the "About Your Health Care Benefits" document.

Claims and Appeals

You should file a STD claim as soon as you know you will be out of work for more than seven calendar days due to a non-work related illness or injury (work related illness or injury is covered under Workers' Compensation).

To file a claim, call ConnectOne at 1-800-881-3938. You will be referred to MetLife, the Claims Administrator for the STD Plan.

The Claims Administrator will provide you with the appropriate forms and can help you file for statutory disability benefits where applicable.

You should expect to provide the Claims Administrator with the following information when you call:

- Personal information such as name, SSN, date of birth, and current contact information;
- Employment information including your manager's name and contact information, your occupation, your last day worked (prior to your disability), and when you expect to return to work;
- Medical information including details on your illness or injury, dates of treatment, name and contact information for your physician(s).

After you report a claim, the Claims Administrator will contact you if any additional information is necessary for them to evaluate your claim. Once the Claims Administrator has collected and reviewed all of the relevant data, a case manager will approve or deny your claim. Benefits are approved for a fixed period of time, as determined by the case manager. The initial approval period is an estimate of how long it would take a regular person to recover from your disabling condition and may be adjusted based on medical information or other extenuating circumstances.

The case manager will notify both you and your manager of the Claims Administrator's decision regarding your claim. The Claims Administrator will specify a date that you are expected to return to work from an approved claim. If you are unable to return to work on the specified date, please contact the Claims Administrator immediately.

MetLife, the Claims Administrator, has been delegated the responsibility as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

Except as otherwise prescribed by the rules of the Plan Administrator or Claims Administrator, the procedures will be as follows.

The Claims Administrator has 45 days from the date it receives your claim for disability benefits to determine whether or not benefits are payable in accordance with the terms and provisions of the Plan. The Claims Administrator may require more time to review your claim if necessary due to circumstances beyond its control. If this should happen, the Claims Administrator must notify you in writing that its review period has been extended for up to two additional periods of 30 days, as warranted. If this extension is made because you must furnish additional information, these extension periods will begin when the additional information is received. You have up to 45 days to furnish the requested information.

During the review period, the Claims Administrator may require a medical examination of the insured, at its own expense; or additional information regarding the claim. If a medical examination is required, the Claims Administrator will notify you of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations will delay the claim process. If additional information is required, the Claims Administrator must notify you, in writing, stating the information needed and explaining why it is needed.

If your claim is approved, you will receive the approved benefit from the Claims Administrator.

If your claim is denied, in whole or in part, you must receive a written notice from the Claims Administrator within the review period. The Claims Administrator's written notice must include the following information:

- The specific reason(s) the claim was denied.
- Specific reference to the Plan provision(s) on which the denial was based.
- Any additional information required for your claim to be reconsidered, and the reason this information is necessary.
- Identification of any internal rule, guideline or protocol relied on in making the claim decision, and an explanation of any medically-related exclusion or limitation involved in the decision.
- A statement informing you of your right to appeal the decision (including your right to file a claim under Section 502(a) of ERISA in the event of an adverse benefit determination upon review), and an explanation of the appeal procedure, as outlined below.

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Claims Administrator within 180 days of the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal.

Once your request has been received by the Claims Administrator, a prompt and complete review of your appeal must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the original claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the appeal, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Claims Administrator will be identified. You may also submit issues and comments that you believe might affect the outcome of the review.

The Claims Administrator has 45 days from the date it receives your request to review your appeal to notify you of its decision. Under special circumstances, the Claims Administrator may require more time to review your appeal. If this should happen, the Claims Administrator must notify you, in writing, that its review period has been extended for an additional 45 days. Once its review is complete, the Claims Administrator must notify you, in writing, of the results of the review. If your appeal is denied, the Claims Administrator's notice must include the following:

- The specific reason(s) the appeal was denied;
- Specific reference to the Plan provision(s) on which the denial was based;

- Upon request and free of charge, you are entitled to reasonable access and copies of all documents, records and other information relevant to your appeal for benefits; and
- Identification of any internal rule, guideline or protocol relied on in making the appeal decision, and an explanation of any medically-related exclusion or limitation involved in the decision.

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 Plan within 12 consecutive months after the date of receiving a final determination on review of your appeal, or if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan 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 Plan 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 Plan is final.

Important Administrative Information

This section contains general information about the administration of the Plan, the Plan document, the Plan sponsor, and the Claims Administrator. In addition, a statement about the future of the Plan and Citigroup's right to amend, modify, suspend, or terminate is outlined in this section.

Future of the plan and plan amendments

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

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.

No right to employment

Nothing in this document represents or is considered an employment contract, and neither the existence of the Plan or any statements made by or on behalf of Citigroup shall be construed to create any promise or contractual right to employment or to the benefits of employment. Citigroup or you may terminate the employment relationship without notice at any time and for any reason.

Plan administration

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

This authority includes, but is not limited to, the prescription of rules for the operation of the Plan and setting requirements that the fiduciary deems reasonable for evidence of eligibility for benefits, such as medical reports, independent medical examinations, and occupational research.

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

- To administer and manage the Plan including the processing and payment of claims under the Plan 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 Plan; and
- To act as Claims Administrator and to review claims and claim denials under the Plan to the extent another insurer or administrator is not empowered with such responsibility.

The delegation by the Plan Administrator may (but is not required to) be in writing. Except to the extent superseded by laws of the United States, the laws of New York will be controlling in all matters relating to the Plan.

The Plan Year is the calendar year (January 1 -December 31).

Funding and payment policy

Benefits under the STD Plan are paid from the general assets of Citigroup or from a trust qualified under Section 501(c)(9) of the Internal Revenue Code. Benefits under the LTD Plan are funded through an insurance contract. The cost of the short term disability benefits is borne by Citigroup; the cost of the long term disability benefits is borne by Citigroup and participating employees. 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. Payments under the Plan shall be made in accordance with Plan terms, insurance policies, or administrative agreements.

Continuation of Other Benefits

If you are on an approved long term disability, call the Benefits Service Center about your eligibility to continue medical, dental, vision care, and/or spending account coverage. Except as indicated below, your benefits continue when you qualify for short term disability benefits with contributions being withheld from your benefit payments. You will be billed directly for your regularly scheduled contributions in order to remain covered under Citigroup benefit plans while you are receiving disability benefits, if your short-term disability payments are insufficient to cover your contributions and during any period of long term disability.

You are entitled to 52 weeks of disability benefits (from the first day of your short-term disability) as an employee of Citigroup. If you continue to be disabled after this time, your employment is terminated. If you temporarily recover (return to work for a period of less than 6 months) while receiving a LTD benefit, you may not be required to satisfy a new elimination period to continue LTD benefits upon a relapse related to the same or related disability. The time you receive disabililty benefits following the relapse will be added to your initial disability period until you have accumulated a total of 52 weeks of disability benefits, at which time, your employment will be terminated. If you return to work and discontinue your LTD benefit for a period of less than 6 months before accumulating 52 weeks of disability benefits, the time at work is not included for purposes of determining when you have had 52 weeks of disability coverage for purposes of terminating your employment. Only the time you are receiving disability benefits is taken into consideration for this purpose.

Your Basic Life/AD&D Insurance and Business Travel Accident Insurance will continue at no cost to you for the first 52 weeks of your disability. After 52 weeks, you may convert your coverage to an individual policy by calling MetLife at 1-800-523-2894. For the first 13 weeks of your disability (i.e. short term disability), you may continue your Group Universal Life Insurance at active rates. Your premiums will be payroll deducted from your short term disability benefit payments. After 13 weeks, you will be billed directly for monthly premiums. Failure to pay premiums will result in the termination of your coverage. After 52 weeks of disability, your coverage under both Basic Life/AD&D and Group Universal Life programs will stop. You are entitled to convert your Basic Life/AD&D into an individual policy and continue your GUL coverage through direct billing by contacting MetLife within 31 days of your termination to continue such coverages at higher rates. Notwithstanding the foregoing, if your employment terminates as a result of a disability on or after August 1, 2007, and you convert your GUL coverage, you will continue to pay active rates for GUL coverage for the duration of the time you are entitled to continuation of medical coverage under the Citigroup medical plan based on your disability (and years of service, see chart on page 10). When you are no longer eligible for continuation of medical coverage under the plan, your GUL rates will increase to a higher rate.

After 52 weeks, you can convert your Business Travel Accident 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 (i) your coverage under the policy as an employee and (ii) $500,000.

Your Vision coverage will end after 13 weeks of disability but you may continue coverage through Davis Vision.

After 13 weeks of disability, you may continue Health Care Spending Account (HCSA) coverage through COBRA until the end of the calendar year. Contributions will be on an after-tax basis. Commencing at the start of your short term disability, you will no longer be eligible to contribute to a Dependent Care Spending Account (DCSA) or to the Transportation Reimbursement Incentive Program (TRIP).

After 13 weeks of disability, your eligibility to make 401(k) contributions will cease. If you have an outstanding loan, you will have the option to pay the loan in full, or continue making monthly payments by personal check.

In applicable states, you will be paid for any earned and unused vacation days that were available to you at the time your disability began. You will begin earning vacation days on the day you return on a full-time basis. Any earned and unused floating holidays will be forfeited, except in the state of California.

If you return from your disability, your medical, dental, and Group Universal Life Insurance will continue. Premium payments will resume through payroll deductions. You will have the option to re-enroll in the Vision Plan and the Flexible Spending Accounts. To re-enroll, you must contact the Benefits Service Center within 30 calendar days of your return to work. You can also re-enroll in the 401(k) plan by contacting the Benefits Service Center. Any loan repayments will resume through payroll deductions.

If you are still on disability leave after 52 weeks (from your first day of short term disability), your employment will be terminated. Thereafter, your eligibility to continue to be covered under the medical plan is based on your years of service. For purposes of the Plan (short-term and long-term disability coverage), 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 (or any fraction thereof), counting any part of a month in which you provided services. 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.

- Medical coverage may continue at active employee rates according to the schedule below.

Years of recognized Citigroup service (at the time your long term disability is approved)	**Medical continuation period after week 52 (the termination of your employment)**
Less than 2 years	Six months
2 years to less than 5 years	Equal to years of service (whole or fraction)
5 years or more	As long as employee is disabled or has not reached his/her age limit for receiving long term disability benefits

Note: The continuation period runs concurrent with COBRA (Consolidated Omnibus Budget Reconciliation Act), which allows employees and their covered dependents to continue health care coverage, at their own expense, under certain circumstances when coverage would otherwise end.

- Dental coverage may be continued after 52 weeks of disability through COBRA.
- Vision care may be continued after 13 weeks of disability through Davis Vision.
- Health Care Spending Account (HCSA) coverage may be continued after 13 weeks of disability through COBRA until the end of the plan year.
- Basic life and accidental death and dismemberment (AD&D) insurance is discontinued after 52 weeks of disability, but it may be converted to an individual policy at higher rates by contacting MetLife within 31 days after your termination date.
- Group Universal Life (GUL) and supplemental AD&D insurance is discontinued after 52 weeks of disability, but the coverage is portable and your coverage may be continued at a higher rate by contacting MetLife within 31 days after your termination date. Effective August 1, 2007, you will continue to pay active rates as long as you are entitled to continuation of medical coverage.

- Business Travel Accident coverage is discontinued after 52 weeks of disability, however, you can convert your 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 (i) your coverage under the policy as an employee and (ii) $500,000.

If you're enrolled in a non-HMO medical plan, once you become disabled for more than 29 months, Medicare will become your primary medical coverage while benefits under the Citigroup plan become secondary.

Sick Days and Disability for Certain Legacy Employees

Sick time accrued by legacy employees of Citibank and The Associates was set aside in a "frozen sick bank" as of December 31, 2001. The time is expressed in days and will be kept separate from any time off allocation for 2002 and future years.

If you have a frozen sick bank, you can use the time to supplement your pay in these situations:

- If your Total Compensation is equal to or greater than $50,001, you do not elect long term disability coverage, and you have an approved disability that continues beyond the 13-week short term disability period, you can use your frozen sick bank days to receive 100% of base salary for up to 52 weeks from the first day of your approved disability leave;
- If you use your annual allocation of sick days and need additional time off for an illness or injury of less than a week (time away from work for an illness or injury that doesn't need to be reported to Citigroup's disability administrator), you may be able to use your frozen sick bank days.
- Once your approved disability continues beyond 13 weeks and you have long term disability coverage — either company paid or employee paid — you cannot use frozen sick bank days to offset or supplement the long term disability coverage.

If your Total Compensation is equal to or greater than $50,001 per year and you do not elect employee paid long term disability coverage, you can use your frozen sick time after 13 weeks of short term disability until either you have used all of your sick bank time or you reach week 52. After week 52, your employment will be terminated and you will forfeit all remaining sick days, just as you would if you terminated employment or retired.

If you have questions about possible time in your frozen sick bank, please contact your Human Resources Department or the Managed Disability administrator (MetLife).

The Citigroup Short Term Disability (STD) Plan

Citigroup provides short-term benefits coverage as a core benefit at no cost to covered employees. The STD Plan is intended to provide income protection when an Eligible Employee is out of work due to injury, illness, or pregnancy.

Depending on your years of service with Citigroup, the short term disability benefit will generally provide payments ranging from 60% to 100% of your base salary for an approved disability leave of up to 13 weeks. If you were given credit for past service (either you were rehired or worked in the past for what is now Citigroup or a participating employer), your length of service may be adjusted accordingly.

Eligibility for Short Term Disability Benefits

Eligible Employees are eligible for benefits under the Short Term Disability portion of the Plan, if approved, for the duration of their Total Disability up to a maximum of 13 weeks, as long as they have completed one month of continuous service as an active employee.

Short term disability benefits become payable if you are an Eligible Employee with at least one month of continuous service as an active employee and you incur a "Total Disability" as defined below.

Total Disability

Total Disability for purposes of the STD Plan means that due to a serious health condition, pregnancy, or injury, you are unable to perform the essential duties of your regular occupation for more than seven consecutive calendar days. You are not considered to have a Total Disability if your illness, injury, or pregnancy only prevents you from commuting to and from work. If you are able to perform the essential duties of your job at home or otherwise, and are unable to commute to work, this does not constitute a disability for benefits purposes.

The elimination period is seven calendar days. Beginning the day after you satisfy the elimination period, salary continuation, if eligible and approved, will commence retroactive to your first scheduled work day related to your disability. To qualify, you must be receiving appropriate care and treatment from a licensed health care provider on a continuing basis.

In no event will short term disability benefits be payable to any employee who returns to work on a part-time basis (except for statutory benefits required under applicable state law).

Schedule of Benefits (excluding pregnancy leave benefit)

For Salaried Eligible Employees, the following schedule applies:

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 but less than 1 Year	1	12	13
1 Year but less than 2 Years	4	9	13
2 Years but less than 3 Years	6	7	13
3 Years but less than 4 Years	8	5	13
4 Years but less than 5 Years	10	3	13
5 Years or more	13	0	13

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

Years of Service	Minimum Benefit (% of Total Compensation)	Plus Additional Benefit	Maximum Benefit (% of Total Compensation)	Total Weeks of Benefit
1 Month but less than 3 Years	60%	Commissions	100%	13
3 Years but less than 7 Years	70%	Commissions	100%	13
7 Years or more	80%	Commissions	100%	13

Pregnancy Leave:

For Salaried Eligible Employees:

Years of service	Weeks at 100% of base salary	Weeks at 60% of base salary	Total weeks of benefit
Less than 1 month	0	0	0
1 month to less than 1 year	1	12	13
1 year or more	13	0	13

For Financial Advisors, Financial Advisor Associates, and Investment Associates in GWM and Account Executives in CMB:

Years of service	Minimum benefit (% of Total Compensation)	Plus additional benefit	Maximum benefit (% of Total Compensation)	Total weeks of benefit
Less than 1 month	0			0
1 month to less than 1 year	70%	Commissions	100%	13
1 year or more	80%	Commissions	100%	13

If you are a Global Wealth Management business analyst paid a monthly commission: You will receive STD benefits based on a recoverable draw against commissions.

For employees paid on commission working in the Global Consumer Group: You will receive STD benefits based on a phantom salary (and not based on Total Compensation) . If any commissions are generated while you are on STD leave, they will be paid in addition to the short term disability benefit based on your years of service.

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

Offset for Benefits

Notwithstanding any provision to the contrary, short term disability benefits may be offset by any monies owed to Citigroup and/or by any state benefits, including Worker's Compensation and Social Security disability benefits. However, the Plan does not subrogate salary continuation or short term disability payments.

Taxation of Benefits

Short term disability benefits are taxable as ordinary income. Citigroup will withhold taxes on these benefits, and will also withhold deductions for other employee benefits.

Recurrent Disabilities

A recurrent disability is a Total Disability that results from the same cause as a prior claim for a Total Disability, during a specified period of time. You are able to claim benefits for an approved recurrent disability that occurs during the same period of disability without having to satisfy an additional 7-day elimination period.

Periods of disability for the same or related cause or causes will be considered the "same period of disability" if it recurs within 30 consecutive calendar days of your return to work from the initial approved Total Disability. (One work day is greater than four hours.)

If you return to work and incur a Total Disability again with the same or related condition within this 30-day period, the balance of the short term disability benefits described under **Schedule of Benefits** will resume immediately from the point you are again absent from work for the remainder of the short term disability benefit for a total of a 13 week short term disability benefit.

If either a recurrent disability or an unrelated disability occurs after you returned to work for more than 30 days following an initial disability, you may be eligible for additional short term disability benefits as summarized below:

- Eligible Employees who experience an approved disability after returning to work for more than 30 days are eligible for up to an additional 13 weeks of short term disability benefits
- Eligible Employees of Global Wealth Management who experience an approved disability after returning to work for more than 30 days are eligible for up to an additional 13 weeks of short term disability benefits; however, in no event shall the total period of short term disability benefits payable to such Eligible Employee during any calendar year exceed 26 weeks of short term disability benefits, not including pregnancy leaves.

Statutory Disability Benefits

You may be eligible for statutory disability benefits if you work in California, Hawaii, New Jersey, New York, Puerto Rico, or Rhode Island. Statutory disability benefits will run concurrent with salary continuation.

To file a claim for the following statutory disability benefits, call ConnectOne at 1-800-881-3938 and choose the "Managed Disability" option from the main menu to be connected with MetLife. A MetLife representative will assist you in obtaining the following disability benefits.

- California
- Hawaii
- New Jersey
- New York

- Puerto Rico

If you reside in Rhode Island, to obtain a disability benefit, you must contact the state directly at 401-462-8420. In addition to calling the state, you must also call ConnectOne at 1-800-881-3938 to file a claim under FMLA.

Exclusions

You will not receive short term disability benefits for the following:

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

Returning to Work

The case manager will work with you and your manager regarding any reasonable adjustments to your usual job or accommodations to your work site. Although the case manager will continue to follow-up with Citigroup and with your physician(s) for the duration of your claim, it is your responsibility to keep your manager and your Human Resources department informed of your progress. Citigroup may request that you provide a Fitness for Duty form before you return to work.

The Citigroup Long Term Disability (LTD) Plan

The Citigroup Long Term Disability Plan provides disability income benefits through a group disability insurance policy in the event that you suffer a covered disability. In general, your benefit is 60% of your annual "pre-disability earnings" for the year in which you became disabled, up to a maximum of $500,000, subject to certain offsets for other income. In general, your "pre-disability earnings" for the year in which you become disabled is your Total Compensation, as defined earlier in this document, in effect for that year.

In no event shall the monthly benefit exceed $25,000 per month. Further details about your long term disability coverage can be obtained from the insurance certificate, which is also deemed to be part of the Plan document. Should there be any discrepancy between the provisions outlined in the Plan document and the related insurance certificate produced by MetLife, the provisions of certificate shall prevail.

Eligibility for Long Term Disability Benefits

Eligible Employees are eligible for benefits under the long term disability portion of the Plan so long as they satisfy any eligibility conditions under the Plan and related insurance certificate.

Participation and Total Compensation

In accordance with the terms and provisions of the insurance certificate, Citigroup provides long term disability coverage as a core benefit at no cost to Eligible Employees whose Total Compensation is less than $50,001 per year. Eligible Employees whose Total Compensation is $50,001 per year or greater may elect long term disability coverage and pay premiums via payroll deductions on an after-tax basis at rates prescribed by the insurer or Plan Administrator. Election for long term disability coverage other than during your initial enrollment period as a new hire (or during annual enrollment following the plan year your total compensation exceeds $50,001) or as a result of a qualified change in status will require evidence of good health satisfactory to the Plan Administrator or its delegate (the insurance carrier).

Because an insurance carrier underwrites the long term disability component of the Plan, you should refer to the insurance policy attached as Supplement A to this Plan document in order to obtain more specific policy details for your coverage. The Supplement provides information on the following topics:

- Eligibility
- Amount of Long Term Disability Benefits
- Limitations, Exclusions and Elimination Periods
- Required Contributions
- Effective Date of Coverage
- Definition of Disability
- Work Incentives
- Reduction of Benefits – other Income Benefits

- Limitations for Mental or Nervous Disorders or Substance Abuse
- Pre-Existing Conditions
- When Benefits Begin
- How Benefits Are Paid
- When Benefits End
- Recurrent Disabilities
- Family Survivor Benefits
- Recoupment of Overpayments
- Filing A Claim
- Termination of Coverage

Evidence of Good Health/Changes in Status

If your Total Compensation is $50,001 per year or more, you must elect to have long term disability coverage. If you are a new hire and/or become eligible for benefits, you must elect coverage during the first 31 days following your date of hire or the date you first become eligible for benefits to avoid providing evidence of good health. You will also not need to provide evidence of good health if you elect coverage during the first annual enrollment period that you are required to pay for coverage. If you seek to enroll during a later open enrollment period, you will need to provide evidence of good health to be eligible for coverage.

However, you may be able to elect long term disability coverage without providing evidence of good health, if you elect coverage within 31 days of the occurrence of one of the following qualified changes in status:

- you get married;
- your marriage is dissolved through divorce or civil annulment;
- you legally separate from your spouse;
- your spouse dies;
- the birth, adoption or placement for adoption of a dependent child; or
- your spouse becomes unemployed.

Coverage becomes effective the first day of the month following the date of your request to initially enroll or make a change in your benefits because of one of the above types of qualified change in status.

If you elect other than in connection with a qualified status change, the first annual enrollment when you are required to pay for coverage because of increases in your Total Compensation, or when you become newly eligible for benefits, you will be required to provide evidence of good health, satisfactory to the Plan Administrator or its delegate (the insurance company). Your coverage will become effective only if or when your evidence of good health is approved.

Participation in the long term disability portion of the Plan is voluntary and you may cancel your coverage at any time.

To cancel your coverage or to enroll due to a qualified change in status, call ConnectOne at 1-800-881-3938.

Elimination Period

In no event will benefits under the LTD Plan commence before satisfaction of an "elimination period" as determined under the Supplement (i.e., the insurance certificate). If you incur an approved disability and return to work during your elimination period and you become disabled again with the same or related condition within 30 days of your return to work from the initial approved disability, you will not have to begin a new elimination period. However, the days worked during such temporary recovery will be added to your elimination period, and in no event will benefits under the LTD Plan commence before satisfaction of such extended elimination period. If you return to work for more than 30 days, you will have to begin a new elimination period.

Conversion Privilege

You may be eligible to convert up to $3,000 per month of MetLife group coverage to an individual long term disability policy when your employment with Citigroup ends, as long as you were enrolled in the LTD Plan for the 12 months prior to your termination and you are not retiring from Citigroup. For this purpose, you are generally considered eligible to retire when you terminate employment with all participating employers after attaining age 55 with at least five years of service or effective for terminations on or after March 1, 2007, after attaining age 50 with at least 10 years of service. The conversion policy only provides coverage for long term disability. Evidence of good health will not be required.

The conversion policy will be issued under the terms and conditions established by the insurance company. Therefore, the format, benefits provided, premium, and other terms of the conversion coverage may differ from those provided under the LTD Plan. You must contact the Benefits Service Center through ConnectOne to apply for the conversion plan within 31 days after your employment with Citigroup ends.

SUPPLEMENT A

Supplement A shall cover all Eligible Employees who participate in the long term disability portion of the Plan. Coverage for these employees is provided by MetLife.

The following insurance certificate from MetLife provides complete information about your long term disability benefits. In cases where the information in the Supplement differs from the information described previously, the information in the Supplement prevails. In the event of a conflict between the terms of the Plan and the terms of the Supplement, the Supplement shall control as to those Participants receiving coverage under this Supplement. For this purpose, the Supplement shall control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates. To the extent that the terms of this Plan are not in conflict with the Supplement, the Plan Administrator may interpret, enforce, or add terms to the extent that the Plan Administrator deems necessary for the proper administration of the Plan, consistent with the Supplement, and consistent with the purpose of the Plan.