Eligibility and Participation

Your Citi health and welfare benefits are a valuable part of the rewards of working at Citigroup Inc. ("Citi"). To make the most of your benefits, you need to understand how they work. This section describes the eligibility and participation rules for the following Citigroup health and insurance plans (collectively, the "Plans," and individually, a "Plan"):

- Medical (including the ChoicePlan 500, High Deductible Health Plan and HMOs);
- Prescription Drug;
- Dental (including MetLife Preferred Dentist Program (PDP) and Cigna Dental HMO);
- Vision;
- Wellness Benefits;
- Spending Accounts;
- Be Well Program;
- Disability Coverage;
- Insurance Benefits (including Basic Life, Basic Accidental Death and Dismemberment (AD&D), Group Universal Life (GUL), and Supplemental AD&D)
- Business Travel Accident and Business Travel Medical
- MetLife Legal Plans.

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Benefits Overview

Citi provides a basic level of benefits coverage, called core benefits, as well as the opportunity to enroll in additional coverage for yourself and your family. Coverage is effective on your date of hire or the date you become eligible for benefits. Other than the core and non-core LTD (you are automatically enrolled upon initial eligibility with an option to decline the LTD coverage) benefits, you must enroll to have coverage.

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

- **Short-Term Disability (STD) coverage**, administered by MetLife; coverage to replace generally 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;
- **Long-Term Disability (LTD) coverage**, administered by MetLife, equal to 60% of your benefits eligible pay, provided your benefits eligible pay is less than or equal to $50,000.99;
- **Basic Life insurance**, equal to your benefits eligible pay if less than $200,000, on your date of eligibility. Basic Life insurance is insured by MetLife; if your benefits eligible pay is equal to or exceeds $200,000, you are not eligible for Basic Life insurance;
- **Basic Accidental Death and Dismemberment (AD&D) insurance**, equal to your benefits eligible pay if less than $200,000, on your date of eligibility. Basic AD&D insurance is insured by MetLife; if your benefits eligible pay is equal to or exceeds $200,000, you are not eligible for Basic AD&D insurance;
- **Business Travel Accident/Medical (BTA) insurance**, administered by Chubb USA, of up to five times your benefits eligible pay to a maximum benefit of $2 million while traveling on behalf of Citi; and medical coverage related to covered accidents and/or sickness while traveling outside your home or assigned country on behalf of Citi;
- **Be Well Program**, administered by Humana; a 24/7, confidential, professional counseling service designed to help you and your household members resolve issues that affect your personal lives or may interfere with job performance; including therapy services provided through text messaging.
  - **Work/Life Program**, part of the Be Well program administered by Humana; helps employees save time as they face common everyday challenges; services include helping employees find child and elder care, providing up to 30 minutes of free legal assistance, helping with identity theft, and more.
- **Live Well at Citi Program**, administered by Health Advocate and Virgin Pulse; Citi's comprehensive health and wellness program provides you and your family with tools and resources designed to assist you in managing your health care and achieving your health goals;

Additional benefits to consider that require enrollment:

- Benefits paid with before-tax dollars (as long as you are receiving a paycheck):
  - Medical (including the Health Savings Account [HSA] if you are enrolled in the High Deductible Health Plan [HDHP]);
  - Dental;
  - Vision;
  - Health Care Spending Account (HCSA);
  - Limited Purpose Health Care Spending Account (LPSA);
  - Dependent Day Care Spending Account (DCSA) and
  - Transportation Reimbursement Incentive Program (TRIP).

- Benefits paid with after-tax dollars:
  - Long Term Disability (LTD), if your benefits eligible pay is $50,001 and above; if your benefits eligible pay is below this amount, LTD is a core benefit provided at no cost to you;
  - Group Universal Life (GUL) insurance;
  - Supplemental AD&D insurance; and
  - MetLife Legal Plans.

Eligibility

Citi provides benefits coverage for you, your spouse/partner and/or eligible dependents.

For Employees

You are considered an eligible U.S. Citi employee for health and welfare benefits if:

- You work in any U.S. entity in which Citi owns at least an 80% interest (U.S. employees of Global Consumer Banking, Institutional Clients Group, Corporate Center or one of their participating employers participate in the Plans as well as certain other employees of affiliated companies as described in the Plan; for a complete list of all the participating employers, please contact the Citi Benefits Center);
- You are an active:
  - Full-time employee (regularly scheduled to work 40 or more hours a week); **or**
  - Part-time employee (regularly scheduled to work at least 20 or more hours a week); **and**
  - You receive regular biweekly or monthly pay; and
- You are employed by a participating employer.

Note: If you are hired as a temporary employee and work for at least 90 days, and you satisfy the definition of a part-time or full-time employee noted above, you become benefits eligible on the date you have been employed 90 days, without regard to the temporary classification.

A “participating employer” is Citi and any subsidiary in which Citi owns at least an 80% interest. For purposes of determining whether you are an eligible employee under the Plans, you are an “active” employee if you are working for your employer doing all the material and substantial duties of your occupation at your usual place of business or some other location that your employer’s business requires you to be or absent from work solely due to vacation days, holiday, or scheduled days off.

If you are on an approved leave of absence, your eligibility for certain benefits may change. Refer to the “Continuing Coverage” section within this document for additional details.

If Both You and Your Spouse/Partner Are Citi Employees

If both you and your spouse/partner are employed by Citi 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 in Citi's Plans as an individual and be claimed as your spouse's/partner's dependent.

Plan	Applicable Rules
Medical, dental and vision	Each of you may be covered under the medical, dental and vision plans as either an employee or a dependent but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Health Care Spending Account (HCSA)	Each of you, as a Citi employee, may contribute to an HCSA, but you may not file more than once for reimbursement of the same eligible expense. However, your partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Internal Revenue Code (the "Code") as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
Limited Purpose Health Care Spending Account (LPSA)	If either of you enrolls in the Citi High Deductible Health Plan (HDHP), either of you may contribute to an LPSA, but you may not file more than once for reimbursement of the same eligible expense. You may use this account to be reimbursed only for dental, vision or preventive medical care expenses that are not already covered by the Plan. Neither of you can enroll in the HCSA. Your partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.
Health Savings Account (HSA)	The maximum amount that can be contributed to an HSA for the 2021 calendar year is $3,600 for individual and $7,200 for family coverage. This does not mean that both family members can contribute $7,200 each; it is a combined contribution amount. Citi makes up to a $500 annual contribution for individual coverage and up to a $1,000 annual contribution for employees with family coverage (other than individual). Citi's contribution to your HSA counts toward your annual contribution maximum. Once HSA is established, if you are age 55 or older, you can make an additional catch-up contribution of up to $1,000. You are permitted to elect a contribution (up to the Code maximum) or change your election amount at anytime during the plan year.
Dependent Day Care Spending Account (DCSA)	Either of you may contribute to a DCSA but you may not file more than once for reimbursement of the same eligible expense. You and your spouse/partner cannot contribute more than $5,000 per year to a DCSA combined. Your partner and his/her eligible child(ren) are eligible only if they are considered your tax "dependents" within the meaning of Section 152 of the Code as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof. If your partner's children are not your tax dependents, as noted above, your partner, as a Citi employee, can contribute to his/her own DCSA.
Transportation Reimbursement Incentive Program (TRIP)	Spouses/partners, as Citi employees, must enroll in TRIP on their own behalf.
Group Universal Life (GUL)	Each of you may be covered under the GUL plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Supplemental Accidental Death and Dismemberment (AD&D)	Each of you may be covered under the Supplemental AD&D plan as either an employee or a dependent, but not as both. Either of you may cover your children, but they cannot be covered by both of you.
Live Well at Citi Program	**Health Assessment Reward:** All employees can earn the $150 Live Well Reward for the Health Assessment as long as they were hired (or transferred from a Citi international business) by October 1, 2020 and complete their Health Assessment between October 1 and November 15, 2020. If your spouse/partner is also a Citi employee, he/she can earn the $150 Reward as well. If your spouse/partner is not a Citi employee, he/she can only earn the $150 Reward if he/she is enrolled in a Citi medical plan. If both you and your spouse/partner are Citi employees and you are not enrolled in a Citi medical plan, you both will earn your Live Well Rewards that can be redeemed for gift cards in the Rewards tab of your Virgin Pulse account at https://landing.virginpulse.com/LiveWell or through the Virgin Pulse app. If both you and your spouse/ partner are Citi employees who are enrolled in the Citi medical plan and both complete the Health Assessment, the $300 premium discount will be applied to the employee who has medical coverage for the couple, if applicable. If you both elect individual coverage, the premium discount of $150 will be applied to each individual's coverage. **Tobacco Penalty:** The tobacco penalty is applied per adult with Citi medical coverage per year, regardless of whether both adults work for Citi or not. See "Live Well Tobacco Cessation Program" on page 216 for details.
Be Well Program	You and your household members are covered under this program.
MetLife Legal Plans	If either of you enrolls, the spouse/partner and dependent children are also covered.

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 W-2 Wage and Tax Statement issued by a participating employer;
- You are employed by a Citi subsidiary or affiliate that is not a participating employer;
- You are engaged under an agreement that states you are not eligible to participate in the applicable plan or program;
- You are a non-resident alien performing services outside the United States; or
- You are classified by Citi as an independent contractor or consultant, or you are employed on a temporary basis hired with the intent to work fewer than six months, or you are not classified as an active full-time or part-time employee, as described above. However, if you are hired as a temporary employee and work for at least 90 days, and you satisfy the definition of a part-time or full-time employee noted above, you become benefits eligible on the date you are employed 90 days without regard to the temporary classification.

If you are not eligible for benefits pursuant to the above and are subsequently reclassified as, or determined to be, an employee by the Internal Revenue Service, any other governmental agency or authority, or a court, or any other individual or entity, or if Citi is required to reclassify you as an employee as a result of such reclassification or determination (including any reclassification in settlement of any claim or action relating to your employment status), you will not become eligible to participate in the Plans by reason of such reclassification or determination retroactively. If a person who is not classified by Citi as an eligible employee otherwise satisfies these eligibility rules and is subsequently reclassified by Citi as an eligible employee, such person, for purposes of these Plans, shall be deemed an eligible employee from the later of the actual or the effective date of such reclassification.

If you are a U.S. citizen or legal resident employed outside the United States or if you are otherwise unsure whether you are eligible to participate in the Plans, call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

No Pre-Existing Condition Limitations

None of the Citi medical options have 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.

For Dependents

When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, domestic partner registry certificate or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways. Any requirements for proof of relationship or waiting periods for registered domestic partnerships are also applied to marriages.

Your eligible dependents must live in the United States and generally are:

- Your lawfully married spouse or common-law spouse, if you live in a state that recognizes common-law marriages, or your civil union partner, if you live in a state that recognizes such partnerships; if you are legally separated or divorced, your spouse/partner is *not* an eligible dependent unless mandated by state law; at any time, you cannot cover more than one person as your spouse/partner;
  - **Note:** Because civil union partnerships are recognized by certain states and generally provide the same protection as marriage, civil union partnerships are not subject to the domestic partnership certification process. However, under federal law, civil union partnerships are subject to the same tax treatment as domestic partnerships. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the listed requirements for non-registered domestic partners.

  - When you add a spouse/partner or new dependent to your coverage, you will be required to submit proof of eligibility for the coverage (for example, a marriage license, partnership registration, certification of domestic partnership or birth certificate). Note that domestic partners and spouses are offered all the same benefits and treated the same in all ways.

- Your domestic partner;
- Your civil union/domestic partner's ("partner's) eligible dependents;
- Your children under the age of 26* (dependent children are covered through the end of the plan year in which they turn 26, regardless of whether they are full-time students) who are:
  - Your biological children;
  - Your legally adopted children;
    - For purposes of coverage under the Plans, adopted children will be considered eligible dependents when they are lawfully placed in your home for adoption or when the adoption becomes final, whichever occurs first.
  - Your stepchildren; and
  - Any other children for whom you are the legal guardian in accordance with the laws of the state in which you reside.

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

You may also cover your disabled adult child age 26 or older when you begin employment with Citi and you enroll him or her when you are first eligible to do so. You must have a letter from the Social Security Administration (SSA) declaring your child as disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your health care coverage.

Note: Not all HMOs cover civil union partners/domestic partners and/or their children. For more specific information, contact your HMO directly.

*Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age of 26. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For specific information, contact your HMO directly. For more information on when coverage ends, see "When Coverage Ends" beginning on page 34.

State laws apply only to fully insured plans. See the list of fully insured plans in the Medical subsection of the Health Care Benefits section of this Benefits Handbook.

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

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

For Domestic Partners

You are eligible to enroll your domestic partner who lives in the United States in Citi coverage if you are a U.S. employee who is active or on an approved leave of absence. For GUL insurance to be effective for your domestic partner, you must be actively at work.

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

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

The Company may require you to provide proof of your financial interdependence (or domestic partner's financial dependence) by producing two or more of the following documents:

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

In order for you to cover a domestic partner, you and your domestic partner must first complete forms attesting to your domestic partnership. Alternatively, if your domestic partnership is registered in any state or under any local government authority authorized to provide such registration, documentation of such registration will be accepted as proof of your domestic partnership, without satisfying the previously listed requirements or completing a certification form. If your domestic partnership ends, you and your domestic partner must attest to the termination of your domestic partnership. Alternatively, if your registration (as noted above) is terminated or no longer effective pursuant to state law or local government authority, documentation to that effect will be accepted as proof of the termination of your domestic partnership. You can obtain the required documents to certify your domestic partnership by calling the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance. **You must wait six months from the time your termination attestation form is received before you can add a new domestic partner, unless your domestic partnership is registered.**

The children of your domestic partner are eligible for coverage if they live in the United States, are under age 26 as of December 31 of the plan year that precedes the year for which coverage applies, and they are your domestic partner's:

- Biological children;
- Legally adopted children;
- Stepchildren; or
- Any other children for whom your domestic partner is the legal guardian in accordance with the laws of the state in which he or she resides.

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

You can also cover your domestic partner's disabled adult child when you begin employment with Citi and you enroll him or her when you are first eligible to do so. You must have a letter from the SSA declaring your domestic partner's child as disabled; if you do not have such a letter, your Citi health plan will evaluate the child before adding him or her to your benefits.

Note: Coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age. However, for some HMOs, coverage ends on the last day of the month in which the child reaches the maximum age. For more specific information, contact your HMO directly. For more information on when coverage ends, see "When Coverage Ends" beginning on page 34.

HMO Eligibility

Note: Insured HMOs made available through the Citigroup Health Benefits Plan comply with state laws that require less restrictive age and/or income requirements for dependents. These laws apply only to insured health programs and do not apply to ChoicePlan 500, High Deductible Health Plan or other non-insured (self-funded) programs. This applies to the following plans:

1. Health Plan Hawaii Plus (HMSA);
2. SelectHealth (Utah and part of Idaho);
3. Kaiser FHP of California—Northern; and
4. Kaiser FHP of California—Southern.

For more information, contact the insured HMO provider in your state. Coverage may be available only on an after-tax basis if your covered children are not your tax dependents, and other costs may apply.

Other Coverage

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

However, if you are enrolling in coverage from two sources, be sure you understand how benefits are paid when you are covered by two group medical plans or group dental plans. In many instances, you may pay for coverage from two group plans but you will not receive double benefits or even be reimbursed for 100% of your costs as a result of what is called "coordination of benefits." See "Coordination of Benefits" on page 47 for the guidelines on whose plan pays first.

Health Advocate

Health Advocate can help you understand your benefits and compare the costs and benefits of different plans. Call **1 (866) 449-9933** and select option #1 to speak with your Personal Health Advocate.

Enrollment

You can enroll in Citi coverage within 31 days after the date you first become eligible, during the Annual Enrollment period or within 31 days after the date of a qualified change in status. Your enrollment materials will contain the coverage available to you, the enrollment deadline and how to enroll. You can enroll in any or all types of benefits offered to you.

Coverage Categories

Citi offers four coverage categories for medical and dental coverage:

- **Employee Only:** Coverage for you only;
- **Employee Plus Spouse/Partner:** Coverage for you and your spouse/partner only;
- **Employee Plus Children:** Coverage for you and your eligible children including the eligible children of your spouse/partner; and
- **Employee Plus Family:** Coverage for you, your spouse/partner, your eligible children and your spouse's/partner's eligible children.

You can choose a different coverage category for medical and dental. For example, you might enroll in "Employee Only" coverage for medical if your spouse/partner has medical coverage from his or her employer and "Employee Plus Spouse/Partner" for dental coverage if your spouse's/partner's employer does not offer dental coverage.

Each category has a different cost. In addition, your cost for medical coverage will depend on your benefits eligible pay band as defined in "Your Contributions" on page 22. You will find your costs in your enrollment materials.

For vision coverage only: If you elect vision coverage, you must designate a level of coverage (one person, two people, or three or more people). You do not need to be enrolled in the vision plan to enroll a dependent for vision coverage.

As a New Hire or Newly Eligible for Benefits

As a newly hired benefits eligible employee, or if you are newly eligible for benefits, you will have 31 days from your date of eligibility to enroll in Citi Benefits. *Enrolling in Citi health and welfare benefits is not mandatory.* The penalty for not having health coverage under the Affordable Care Act is no longer applicable; however, certain states impose a penalty for not having health coverage. You must enroll during your initial enrollment period for benefits (except core benefits), including medical, dental and vision coverage. You must also enroll to participate in a Health Care Spending Account (HCSA), Limited Purpose Health Care Spending Account (LPSA), Dependent Day Care Spending Account (DCSA) or the Transportation Reimbursement Incentive Program (TRIP). You are not required to enroll in TRIP during Annual Enrollment; you can enroll at any time. If you do not enroll, you will have the core benefits, described in "Benefits Overview" on page 12.

Dependent Verification

The first time you enroll new dependents in Citi Benefits, you will be asked to report information about each of your eligible dependents, such as name, date of birth, Social Security number and, if over age 26, whether the child has a mental or physical disability. You will also be required to submit proof of the dependent's eligibility for coverage. For more information on the dependent verification process, see "For Dependents" on page 15, under "Eligibility" beginning on page 13.

You are required to provide the Social Security number of each of your dependents. However, if your dependent does not have a Social Security number at this time, you should notify the Citi Benefits Center. **Note:** Not having a Social Security number on file may delay the timely payment of claims.

You must also keep your dependent information current:

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

If You Do Not Enroll

If you do not enroll in coverage within your initial 31-day enrollment period, you can enroll during a subsequent Annual Enrollment period or as the result of a qualified change in status. **Note:** You generally have 31 days from the date of a qualified change in status to enroll in or change your coverage in connection with the qualified change in status See “Changing Your Coverage” beginning on page 27 for more information.

You are not permitted to add, drop or change coverage in the MetLife Legal Plans mid-year due to a qualified change in status.

The penalty for not having health coverage under the Affordable Care Act is no longer applicable; however, certain states impose a penalty for not having health coverage.

During Annual Enrollment

Which Plan Is Right for You?

Ask ALEX, the fun, interactive virtual benefits guide, can help you choose the medical plan that’s best for you and your family. You can access the tool during Annual Enrollment, if you have a qualified change in status, or as a new hire.

If you want to enroll in Citi coverage; drop Citi coverage; change to a different medical, dental or vision option; enroll in a spending account; or change your coverage category — for example from single to family or vice versa — you must do so during your Annual Enrollment period. Outside of Annual Enrollment, generally you can only make changes to your coverage if you have a qualified change in status, such as getting married. Benefit changes must be made within 31 days of the qualified change in status. See “Changing Your Coverage” beginning on page 27 for more information.

Medical, Dental and/or Vision Coverage

If you previously enrolled in coverage and do not enroll during a subsequent Annual Enrollment period, you will be assigned the same coverage for the following year, or, if that coverage is no longer available, to comparable medical, dental and/or vision coverage.

If you do not complete the Tobacco Free Attestation on Your Benefits Resources™, available through My Total Compensation and Benefits at **www.totalcomponline.com**, before your enrollment deadline, you will pay a $600 penalty on your Citi medical plan coverage.

Health Care Spending Account (HCSA)/Limited Purpose Health Care Spending Account (LPSA), and/or Dependent Day Care Spending Account (DCSA)

You must enroll each year to have coverage.

Health Savings Account (HSA)

You must enroll in the High Deductible Health Plan (HDHP) option under the medical plan to be potentially eligible to establish an HSA. To satisfy all the requirements to be eligible to establish an HSA, you must accept the Terms and Conditions of the program and satisfy Citi’s policies and procedures required to establish an HSA to complete your enrollment. If you do not elect an annual contribution amount, you will only receive Citi’s contribution; no additional contributions will be made to your HSA.

Basic Life and Basic Accidental Death & Dismemberment (AD&D) Coverage

If your benefits eligible pay, for benefits purposes, increases to $200,000 or above in connection with benefits coverage that will be effective on January 1 of any subsequent plan year, you'll be ineligible for company-paid Basic Life/Basic AD&D coverage. However, if you have not previously elected the maximum coverage under GUL insurance, during Annual Enrollment you'll have the opportunity to enroll in or increase your GUL insurance equal to one times your benefits eligible pay, not to exceed $500,000, without providing evidence of insurability.

If you become ineligible for Basic Life and Basic AD&D coverage due to an increase in your benefits eligible pay, you may convert your Basic Life and AD&D coverage without providing evidence of insurability within 31 days of receipt of the loss of coverage notice.

Long-Term Disability (LTD) Coverage

If, as a newly hired employee, your benefits eligible pay exceeds $50,000.99, you may be automatically enrolled in LTD coverage with an option to decline coverage, described below. If your benefits eligible pay, for benefits purposes, increases above $50,000.99 in any plan year, you may be automatically enrolled in LTD coverage for the following year during Annual Enrollment with payroll deductions beginning January 1. (Evidence of insurability will *not* be required at this time.)

If you do not want LTD coverage, you may choose "no coverage" when you make your elections during Annual Enrollment (or enroll as a new hire). However, if you do not make an election, you will be automatically enrolled in LTD coverage. You may elect to retroactively decline coverage for up to 90 days after January 1 (or 90 days after enrollment as a new hire), and receive a refund of premiums paid. You may elect to decline coverage after the initial 90-day period passes; however, you will not receive a premium refund.

Company-paid LTD coverage is available only to eligible employees whose benefits eligible pay is less than or equal to $50,000.99.

MetLife Legal Plans

You can enroll each year during Annual Enrollment (or as a new hire) to have coverage. Midyear changes are not permitted under this Plan, even if you have a Qualified Status Change that allows you to change other Citi benefits.

Once you are enrolled, your participation will continue as long as you remain eligible, unless you elect to drop coverage during a subsequent Annual Enrollment period.

After You Enroll or Default

Confirmation of Enrollment

A confirmation of enrollment listing your benefits will be mailed to your preferred address of record.

- **If you enroll by telephone:** Review this confirmation statement carefully for accuracy and retain it as proof of your enrollment. If you find an error, to correct it, immediately call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.
- **If you enroll online,** you will receive a confirmation of enrollment email**:** If you find an error, to correct it, immediately call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Confirmation of Default

If you do not enroll, you will have the "default" coverage shown on the Your Benefits Resources™ website, available through My Total Compensation and Benefits at **www.totalcomponline.com**. If you are a new hire, default coverage will also be shown on your Personal Enrollment Worksheet, which would reflect the core benefits that are provided at no cost to you.

A confirmation statement will be mailed to your preferred address of record after your enrollment period ends. The confirmation statement will list your default coverage.

Naming a Beneficiary

Your beneficiary information should be on file with Citi. If you have not designated a beneficiary, visit the Your Benefits Resources™ website through My Total Compensation and Benefits at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

If you do not have intranet or Internet access, call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance. Speak with a Citi Benefits Center representative to name a beneficiary for Basic Life and Basic AD&D insurance and Business Travel Accident/Medical (BTA) insurance.

If you enroll in Group Universal Life (GUL) insurance or Supplemental AD&D insurance, you must complete a MetLife Beneficiary Designation form available on Citi Benefits Online and return it to MetLife at the address on the form. You can also designate or change your beneficiary by visiting the MetLife MyBenefits website through My Total Compensation and Benefits at **www.totalcomponline.com**, available from the Citi intranet and the Internet.

If you retire, the beneficiary you designated while an employee will be carried over to any Company-provided retirement plans you may have until you designate other beneficiaries.

Your Contributions

Your contributions for medical, dental and vision coverage are based on the plan and the coverage category you elect. Your medical contribution also depends on the benefits eligible pay band that applies to you. The employee contributions for the medical plan increase as benefits eligible pay increases. The benefits eligible pay bands for 2021 are shown below.

Benefits eligible pay bands on which employee contributions for medical coverage are based:

- $30,000 or less;
- $30,001 – $40,000;
- $40,001 – $50,000;
- $50,001 - $75,000;
- $75,001 - $100,000;
- $100,001 – $150,000;
- $150,001- $200,000;
- $200,001 - $500,000; and
- $500,001 +.

For purposes of calculating your medical contributions and coverage amounts, benefits eligible pay is determined each year and will apply for the entire calendar year. See “Definition of Benefits Eligible Pay” on page 23.

Note: If your coverage begins during a pay period, your contributions will not be prorated based on having coverage for only part of the pay period.

Before-Tax Contributions

Contributions for medical (including the Health Savings Account [HSA]), dental, vision and spending accounts are made with before-tax dollars as long as you are receiving a paycheck. This means your contributions are deducted from your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore, the amount of income tax you must pay. However, these before-tax contributions may be subject to state or local income taxes in certain jurisdictions.

Citi reports the total value of the health coverage we provide on your Form W-2 Wage and Tax Statement. This is only a reporting requirement and *does not change how your benefits are taxed*.

Social Security Taxes

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

Benefits Eligible Pay and Your Benefits

Benefits eligible pay is used to determine:

- Medical contributions;
- Long-Term Disability (LTD) benefit and, where applicable, LTD contributions;
- Basic Life insurance benefit;
- Basic Accidental Death and Dismemberment (AD&D) insurance benefit;
- Group Universal Life (GUL) insurance and costs;
- Supplemental AD&D insurance and costs;
- Eligibility for the Dependent Day Care Spending Account (DCSA) subsidy;
- Short-Term Disability (STD) benefit for U.S. Consumer Wealth Management employees who hold the title of Senior Wealth Advisor or its equivalent; and
- Business Travel Accident/Medical (BTA) insurance benefit.

Definition of Benefits Eligible Pay

Enrolling During the Annual Enrollment Period

If you are enrolling during the Annual Enrollment period for coverage effective January 1, 2021, your benefits eligible pay for purposes of benefits enrollment is made up of the following:

1. Annual base pay of current year as of June 30, 2020;
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, 2019, will be used for the 2021 Annual Enrollment calculation;

3. Cash bonuses (other than the cash portion of any annual discretionary incentive/retention award package) paid in the period January 1 – December 31 in the year prior to enrollment; cash bonuses paid in the period January 1 – December 31, 2019, excluding the cash portion of the annual discretionary incentive award/retention package dated January 2019, will be used for the 2021 Annual Enrollment calculations;
4. Annual discretionary incentive/retention award package dated in the year of enrollment includes, as applicable, cash bonus, Capital Accumulation Program (CAP) Award and Deferred Cash Award. Annual discretionary incentive/retention award packages dated January/February 2020 will be used for the 2021 Annual Enrollment calculation; and
5. Short-Term Disability (STD) benefits paid from January 1 – December 31, 2019, for employees paid commissions only.

If You Are Enrolling as a New Hire or Newly Eligible Employee

Your benefits eligible pay at the time you are hired (if after June 30, 2020) is equal to your annual base salary. If you are to be paid commissions only, your benefits eligible pay is calculated differently and is based either on a default amount or an amount established as appropriate for your position. Ask your HR representative for details.

For future years, your benefits eligible pay will be based on a formula that includes your actual base pay plus commissions, performance-based bonuses and annual incentive bonus. Your benefits eligible pay for subsequent years will be determined under the Plan rules for Annual Enrollment as noted above.

Note: Your benefits eligible pay does not necessarily equal the amount reported as salaries and wages on your Form W-2 Wage and Tax Statement ("Form W-2").

For Wealth Advisors and Senior Wealth Advisors (formerly Financial Advisors)

In your first year of employment, your benefits eligible pay is considered to be your annual base salary as of when you were hired. If you earned more than your Citi annual salary 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 HR within 30 days of your hire date. To submit your prior year Form W-2, e-mail it to hrsharedservicesnam.hrsupport@citi.com using the subject line "Benefits Eligible Pay Update – FA W2 - Your GEID." If you submit the prior year's Form W-2, for purposes of benefits, your benefits eligible pay will include the amount in Box 1 from your Form W-2 plus all before-tax contributions, including, but not limited to, amounts for adoption assistance, health insurance premiums, health spending accounts, health savings account and 401(k) plan contributions to determine the amount of your benefits eligible pay.

If you decide to provide a copy of the Form W-2, your Basic Life and Basic Accidental Death & Dismemberment (AD&D) insurance amounts, if applicable, will be set at the higher amounts shown on the Form W-2. (Basic Life and Basic AD&D are available only to those employees whose benefits eligible pay is less than $200,000.) Your contributions for medical coverage, Group Universal Life (GUL) amount and Long-Term Disability (LTD) benefits and contributions will also be based on the higher amount.

Your decision to have your benefits eligible pay set at your annual base salary at Citi or based on your Form W-2 Wage and Tax Statement amount from a former employer is irrevocable.

The list of items that constitute benefits eligible pay under the Plan is exclusive and shall not include any extraordinary payments, including, but not limited to, those related to settlements or forgivable loans or any other amounts 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 Become Disabled

In the event that you go out on a disability, your benefits eligible pay will be recalculated for annual enrollment after you return from the disability leave, if your leave extends beyond the benefits eligible pay calculation period for purposes of annual enrollment for the 2021 plan year or beyond. Your benefits eligible pay will not change while you are out on a disability leave.

Partner Benefits

Citi offers benefits coverage to your certified or registered domestic partner, regardless of gender or gender identity. (You must submit a domestic partner coverage application or your registration, as applicable, before you can enroll a domestic partner or a domestic partner's child(ren) under your Citi coverage.) Citi also offers benefits coverage to your civil union partner and his or her eligible dependents.

You may cover your domestic partner/civil union partner ("partner") and his or her eligible children under the following plans:

- Medical;
- Dental;
- Vision;
- Health Care Spending Account (HCSA), provided your partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; (**Note:** Partners who are not considered tax dependents under Section 152 cannot have their claims reimbursed under the Health Care Spending Account);
- Limited Purpose Health Care Spending Account (LPSA), provided your partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof;
- Dependent Day Care Spending Account (DCSA), provided your partner and his or her eligible children are considered tax dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof; and
- Group Universal Life (GUL) and Supplemental Accidental Death & Dismemberment (AD&D) insurance for partners and life insurance for children.

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

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

When You Can Enroll Your Partner

You can enroll your partner and his or her eligible children in Citi medical, dental, vision and spending account benefits during Annual Enrollment (for coverage effective January 1 of the following year) or within 31 days of a qualified change in status. See "Changing Your Coverage" beginning on page 27 for more information.

Examples of qualifying events that will allow you to enroll your partner and his or her eligible children during the plan year are:

- Submitting your registration or certifying your domestic partnership by submitting the Domestic Partner Coverage Forms;
- The birth or adoption of a child; and
- Your partner's loss of benefits coverage in another employer's plan.

You must speak with a Citi Benefits Center representative to request the Domestic Partner Coverage Forms, if applicable. See the *For More Information* section for detailed instructions, including TDD and international assistance.

For information on domestic partner eligibility, see "For Domestic Partners" on page 17 under "Eligibility" beginning on page 13.

Cost of Partner Benefits

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

If your partner and his or her child(ren) qualify as your dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof, your contributions for partner medical, dental and/or vision coverage will be taken on a before-tax basis. However, if your partner and his or her child(ren) do not qualify as dependents for federal income tax purposes as described above, you will pay for their medical, dental and/or vision coverage with after-tax dollars.

Tax Implications

According to federal tax law, your taxes may be affected when you enroll your partner in Citi coverage. This Benefits Handbook does not address state and local tax treatment. For information on how tax law may apply to your personal situation, consult your tax adviser.

On the Certification of Domestic Partnership you will need to certify the tax status of your domestic partner and his or her children.

If Your Partner Qualifies as a Tax Dependent

If your partner and his or her children qualify as dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and d(1)(B) thereof, your contributions for their medical, dental and/or vision coverage will be deducted from your pay before taxes are withheld, and there are no tax implications for you. Since the requirements are complex, consult your tax adviser for information on how partnership benefits will affect your taxes and those of your partner.

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

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

You may, but are not required to, certify whether partner and his or her dependent children qualify as dependents under Section 152 of the Code, as determined without regard to subsections (b)(1), (b)(2) and d(1)(B) thereof. If no certification is on file with Citi, the benefits are considered taxable.

If Your Partner Does Not Qualify as a Dependent for Tax Purposes

Generally, medical, dental and vision coverage are not taxable benefits if they are provided to you, your spouse or your dependents. However, if your partner and your partner's children do not qualify as your dependents for income tax purposes, the value of their coverage is considered taxable income to you.

This additional income, known as "imputed income," will be shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. You will be required to pay taxes on this additional income, as required by the Code.

Example: Total Citi cost for Employee Only coverage is $450 per month. Total Citi cost for Employee Plus Spouse/Partner coverage is $900.

The additional $450 cost for Employee Plus Spouse/Partner coverage (known as imputed income) will be treated as taxable income to you.

You will see a line item on your pay statement that shows $450 in imputed income. The taxable amount of that benefit (as determined by Citi's Payroll Department) will be deducted from your pay. In this example, $100 in taxes may be deducted from your pay for the $450 in imputed income.

If You Terminate Partner Coverage

To terminate partner coverage, you must complete a form attesting that your partnership has ended or submit a document showing the termination of your partner registration, as applicable. To request the form, call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance. Taxes paid on the imputed income are not refundable.

Your partner and his or her children will be eligible to continue medical, dental, vision and/or HCSA coverage, if applicable, at his or her expense for a period of 36 months.

This coverage will be similar to Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) coverage offered to spouses/partners and other covered dependents. See “COBRA” beginning on page 41 for more information.

If You and Your Partner Marry

Report your qualified change in status to the Citi Benefits Center as soon as possible after your marriage and request that the assessment of imputed income be stopped. You will be required to provide proof of the marriage within 31 days in order to stop the assessment of imputed income permanently. Otherwise, imputed income will continue to be calculated. Call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Note: Changing your marital status and/or number of withholding allowances for payroll purposes will not stop imputed income from being calculated and taxes being withheld. You must call the Citi Benefits Center, as instructed above, to report your marriage.

Changing Your Coverage

Qualified Changes in Status

The rules regarding qualified changes in status apply to coverage elections you make for medical, dental, vision, Health Care Spending Account (HCSA), Limited Purpose Health Care Spending Account (LPSA), Dependent Day Care Spending Account (DCSA), Long-Term Disability (LTD) and Group Universal Life (GUL) insurance.

Please note that the qualified change in status rules do not apply to enrollment in the MetLife Legal Plans. If you enroll during annual enrollment, you will not be able to make a change in your coverage until the next annual enrollment.

In general, the benefit plans and coverage levels you choose during Annual Enrollment remain in effect for the remainder of the following calendar year. However, you may be able to change your elections between Annual Enrollment periods if you have a qualified change in status or other applicable event, as explained below.

You must report to the Citi Benefits Center any change of status that affects your benefits within 31 days of the qualified event by following the process described under “How to Report a Qualified Change in Status Event” on page 31.

Exceptions to the 31-day rule are the loss of Medicaid or Children’s Health Insurance Program (CHIP) coverage and the start of eligibility for state premium assistance. For these two events, you have 60 days to report a change of status and change your benefits.

Important COVID-19-Related Changes that Extend Benefit Deadlines and Allow for Mid-Year Benefit Changes

On December 27, 2020, the Consolidated Appropriation Act 2021 was signed into law, providing additional COVID-19 relief for health care coverage and certain spending accounts. Due to the impact of COVID-19, you have a one-time opportunity to prospectively adjust your current medical, dental, Health Care Spending Account (HCSA), Limited Purpose Spending Account (LPSA) and/or Dependent Care Spending Account (DCSA) election (not drop medical or dental) or add vision coverage without needing to experience a qualified change in status.

While you may be allowed to prospectively enroll, cancel, increase your election amount, or decrease your election amount for your HCSA/LPSA and/or DCSA, you may **not** decrease your goal amount to be below what you have contributed to date. You will be offered an opportunity to enroll or make prospective changes to your 2021 coverage until October 31, 2021.

To make a benefit change, visit Your Benefits Resources™, available through My Total Compensation and Benefits at **www.totalcomponline.com** to complete enrollment, or call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Do not report qualified changes in status to your medical plan carrier. Your medical plan carrier must receive status change information from Citi, not from you.

Depending on the event, you may be permitted to:

- Enroll in or drop your medical, dental, vision, HCSA, LPSA or DCSA coverage;
- Increase or decrease the amount of your HCSA, LPSA or DCSA coverage;
- Enroll in LTD without having to provide evidence of good health; and
- Enroll in or increase GUL insurance without having to provide evidence of good health. (You may increase your coverage if the first, second, third or sixth events below apply. When you experience one of those events, if you have not elected the GUL maximum benefit, you may elect to increase your GUL coverage by one times your benefits eligible pay, not to exceed $500,000, without providing evidence of insurability. Initial election of spouse/partner or child coverage under this program, respectively, is available if you marry, establish an eligible partnership or in the event of the birth or adoption of a child.)

Examples of qualified changes in status are:

1. Your marriage, legal separation or divorce;
2. Meeting the eligibility to qualify as a partner;
3. The birth or adoption of a child;
4. The loss of coverage eligibility for a dependent child who, for example, becomes ineligible due to age;
5. The loss of coverage under your spouse's/partner's or other employer's plan;
6. The death of a spouse/partner or dependent child;
7. The issuance of a Qualified Medical Child Support Order (QMCSO);
8. Relocation outside your medical and/or Cigna Dental HMO's network area;
9. The start of a military leave of absence;

10. The loss of group Basic Life insurance;

    - If your benefits eligible pay for benefits purposes increases such that you become ineligible for company-paid Basic Life and Basic AD&D, this loss of coverage constitutes a qualified change in status for enrollment in GUL insurance. If you have not previously elected the maximum coverage under GUL, during Annual Enrollment you can elect GUL equal to one times your benefits eligible pay, not to exceed $500,000, without providing evidence of good health.

11. The loss of CHIP coverage; and

12. The start of eligibility for state premium assistance.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plans, as long as you and your dependents are eligible but not already enrolled in the Plans. This is called a "special enrollment" opportunity, and you must call the Citi Benefits Center and ask to enroll within 60 days of being determined eligible for premium assistance.

The following is a list of qualified changes in status that will generally allow you to change your elections within 31 days of the occurrence of the qualified change in status (as long as you meet the consistency requirements, as described below). Please note that the 31-day deadline is temporarily extended for qualified life changes that are considered HIPAA Special Enrollment events, due to COVID-19 guidelines. Note that a HIPAA special enrollment event includes loss of eligibility for another group health plan or health insurance that you or your dependents are enrolled in and gaining an eligible dependent through a birth, marriage, or adoption. See "Changing Your Coverage" beginning on page 27 for more information.

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

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

The following are rules that are applicable to a qualified change in status. Any change in benefits request, including the ones discussed below, in connection with a qualified change in status must be made within 31 days of the occurrence of the qualified change in status, except as otherwise indicated.

Consistency Requirements

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

- **Effect on eligibility:** The qualified change in status must affect eligibility for coverage under the Plan or under a plan sponsored by the employer of your spouse/partner or other dependent. For this purpose, eligibility for coverage is affected if you become eligible (or ineligible) for coverage or if the qualified change in status results in an increase or decrease in the number of your dependents who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the qualified change in status. For example, if your dependent loses eligibility for coverage under the terms of the health plan, you may drop medical coverage only for that dependent. Additionally, you may increase or start contributions to an HCSA or an LPSA if you add a dependent. The Plan Administrator will determine whether a requested change is due to a qualified change in status and is consistent with the qualified change in status.

Coverage and Cost Events

In some instances, you can make changes to your benefits coverage for other qualifying events, such as midyear events affecting your cost or coverage, as described below. To change your coverage, the qualifying event must be reported within 31 days; however, in no event will any cost or coverage event allow you to make a change to your HCSA or your LPSA election.

Coverage Events

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

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

Also, if an election change is permitted during a different Annual Enrollment period applicable to a plan of another employer, you may make a corresponding midyear election change.

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

Cost Events

You must contact the Citi Benefits Center within 31 days to make a change as a result of a cost event. Otherwise, your next opportunity to make changes will be the next Annual Enrollment period or when you have a qualified change in status, whichever occurs first.

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

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

Other Rules

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

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

Special note regarding partner coverage: The events qualifying you to make a midyear election change described in this section also apply to events related to a partner. However, IRS rules generally do not permit you to make a midyear change on a before-tax basis for such events unless they involve a tax dependent. Thus, if you make a midyear change due to an event involving your partner, generally that change must be made on an after-tax basis, unless your partner can be claimed as your dependent for federal income tax purposes. See *IRS Publication 17, Your Federal Income Tax,* for a discussion of the definition of a tax dependent. The publication is available at **www.irs.gov/formspubs/index.html**.

Special enrollment rights: If you or your dependents become eligible for premium assistance or lose eligibility for Medicaid or a state's CHIP, you have special enrollment rights under the Plans. You must contact the Citi Benefits Center to request to enroll in coverage under a medical plan option within 60 days of the noted occurrence.

Medicaid and CHIP offer free or low-cost health coverage to children and families.

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

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

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, Citi will permit you and your dependents to enroll in the Plans, as long as you and your dependents are eligible but not already enrolled in the Plans.

How to Report a Qualified Change in Status Event

Generally, you have 31 days from the date of the event (60 days in the event of the loss of Medicaid and CHIP coverage and the start of eligibility for state premium assistance) to report a qualified change in status event and, if applicable, to change your and/or your dependent's coverage. To add a newborn child to your coverage, you must do so within 31 days of the child's birth. See "Changing Your Coverage" beginning on page 27 for more information.

To add a dependent, report the name, date of birth, and, if available, Social Security number for each dependent you want to add or remove from your coverage. If a newborn does not yet have a Social Security number, you must report all other information within 31 days and add the Social Security number once you obtain it. When you add a new dependent to your coverage, you will be required to submit proof of the dependent's eligibility for coverage (for example, a marriage license or birth certificate). If proof is not received by the deadline stated in the dependent verification package, the dependent(s) will be dropped from coverage.

Even if you are already enrolled in Citi family medical, dental or vision coverage, you must report any new dependent; otherwise, your new dependent's claims will not be paid. *Do not report a new dependent to your medical/dental plan.* Your plan must receive the information from Citi, not from you.

When reporting a new dependent whom you wish to enroll in Citi coverage, you may have to change your coverage category. For example: You are enrolled in medical coverage under the "Employee Only" category, and then you get married. If you want to cover your new spouse, you must report information about your new spouse *and* change from the "Employee Only" to the "Employee Plus Spouse/Partner" coverage category. You will be subject to any changes in costs associated with the changes in coverage category.

To report a change in status, and, if applicable, change your coverage category and benefits:

- Call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.
- Visit Your Benefits Resources™, available through My Total Compensation and Benefits at **www.totalcomponline.com**.
- To enroll in Group Universal Life (GUL) insurance or Supplemental AD&D insurance, call MetLife at **1 (888) 830-7380** or access the MetLife MyBenefits website available through My Total Compensation and Benefits at **www.totalcomponline.com**.

Deadline to Report Qualified Changes in Status

You must report or revise dependent information and change your/your dependent's coverage or your coverage category within 31 days (or, where applicable, 60 days) of the qualified change event; otherwise, you cannot change your or your dependent's coverage or your coverage category until the next Annual Enrollment period or until you have another qualified change in status, whichever comes first.

Newborns/Newly Adopted Children

Even if you are not enrolled for dependent coverage, Citi will pay benefits under the Citigroup Health Benefits Plan (self-funded plans) for your newborn child from birth through 31 days. (**Note:** This eligibility provision does not apply to all insured plans; therefore, you should contact your plan for details.) However, if you have coverage under any of the Plan options, you must report this qualified change in status to the Citi Benefits Center within 31 days of the child's birth to add the child to your coverage.

If you do not report the addition of your child during the first 31 days, benefits will not be payable for the child after the 31 days following the date of the child's birth, and, generally, you will have to wait until the next Annual Enrollment period to enroll the child in a plan option unless another qualifying event occurs that would permit coverage to begin at an earlier time. In this case, no payment will be made for any day of confinement, treatment, services or supplies given to the child after the initial 31 days after the child's birth. No other benefits will be paid on behalf of the child.

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

- Extension of benefits; and
- Continuation of coverage.

Remember, you must report information to the Citi Benefits Center about a new dependent even if you already have family coverage. Otherwise, your new dependent will not be covered. New dependent coverage is subject to dependent verification.

Coverage Changes You Can Make at Any Time

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

Long-Term Disability (LTD)

You may enroll in LTD coverage at any time. However, you must provide evidence of insurability except when you enroll as a result of certain qualified changes in status.

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

Group Universal Life (GUL) Insurance

You may enroll in GUL coverage at any time. GUL coverage is administered by MetLife. MetLife does not require evidence of insurability to enroll:

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

However, MetLife will require evidence of insurability if you want:

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

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

Supplemental Accidental Death and Dismemberment (AD&D) Insurance

You may enroll for Supplemental AD&D coverage at any time. Enrollment in this coverage does not require evidence of good health.

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

Health Savings Account (HSA)

You must be enrolled in the High Deductible Health Plan (HDHP) option under the medical plan to be eligible to establish an HSA. You can stop or change your HSA contributions (within the contribution limits) at any time.

Transportation Reimbursement Incentive Program

You can enroll to purchase a transit and/or parking pass online at any time. Enrollments/changes are effective as soon as administratively possible.

When Coverage Begins

This table describes when coverage begins for your medical, dental, vision and spending account coverage.

If:	Then:
You become eligible for Citi Benefits coverage,	You have 31 days to enroll yourself and your eligible dependents. Coverage and contributions will be retroactive to your eligibility begin date (often your date of hire).
You enroll for yourself and your eligible dependents during the Annual Enrollment period,	Coverage will begin on January 1 of the following year.
You enroll in coverage for yourself and/or a new dependent within 31 days of a qualified event; However, if you experience a qualified change in status that is a HIPAA special enrollment event, and your 31-day notification period falls within the Outbreak Period, you may have an additional 31 days after the end of the Outbreak Period to make coverage changes. Note that a HIPAA special enrollment event includes loss of eligibility for another group health plan or health insurance that you or your dependents are enrolled in and gaining an eligible dependent through a birth, marriage, or adoption,	Coverage will begin on the date of the qualified change in status, such as the date of your marriage or divorce, your biological child's birth date or the date your adopted child was placed with you for adoption.
You enroll in coverage for yourself and/or a new dependent as part of a mid-year enrollment change,	Coverage will begin on the date you elect coverage.

When Coverage Ends

Your coverage under the Citigroup Health Benefits Plan, Dental Benefit Plan and Vision Benefit Plan (collectively, the "Plans") will terminate automatically on the earliest of the following dates:

- The date the Plans are terminated;
- The last day for which the necessary contributions are made;
- 11:59 p.m. on the day in which your employment ends (last day of notice period), or you otherwise cease to be eligible for coverage, unless you have attained age 65. If you have attained age 65, your coverage will end at 11:59 p.m. on the last day of the month in which your employment is terminated, or you otherwise cease to be eligible for coverage;
- The day you die; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefits Plan; in such an event, coverage may be terminated retroactively.

Basic Life and Basic Accidental Death & Dismemberment (AD&D) insurance coverage, Short-Term Disability (STD), Long-Term Disability (LTD) and coverage under the Dependent Day Care Spending Account (DCSA), Health Care Spending Account, (HCSA), Limited Purpose Health Care Spending Account (LPSA) and Transportation Reimbursement Incentive Program (TRIP) end on the date your employment is terminated.

You can continue Group Universal Life (GUL) and Supplemental AD&D coverage, or convert your Business Travel Accident (BTA) coverage to an individual AD&D policy by paying MetLife directly. However, your coverage on a group basis will end on the last day of the month your employment is terminated; as such, your premiums will be higher.

Generally, coverage under the MetLife Legal Plans ends on the last day of the month in which your employment is terminated. See the "MetLife Legal Plans" section for additional details about other reasons your coverage may end.

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

- 11:59 p.m. on the day in which your employment is terminated, unless you have attained age 65. If you have attained age 65, your coverage will end at 11:59 p.m. on the last day of the month in which your employment terminated; an exception is your death, in which case coverage will continue for six months if covered survivors elect COBRA;
- The date you elect to end your eligible dependent's coverage as a result of a qualified change in status;
- The date you become legally separated or divorced, submit a partnership termination form or submit other legal documents showing your termination of the relationship to your spouse/partner;
- The last day for which the necessary contributions are made;
- The date your eligible dependent ceases to be eligible for coverage; coverage generally will remain in effect through December 31 of the year in which the child reaches the maximum age (although coverage under some HMOs may end at the end of the month in which the child reaches the maximum age);
- The date the eligible dependent is covered as an employee under the Citigroup Health and Insurance Plans;
- The date the eligible dependent is covered as the dependent of another employee under the Citigroup Health and Insurance Plans;
- The date the eligible dependent enters the armed forces of any country or international organization;
- The date the dependent is no longer eligible for coverage under a Qualified Medical Child Support Order (QMCSO);
- The date defined in the dependent verification package if proof of eligibility is not received by the deadline; or
- Upon a finding of fraud or intentional misrepresentation related to a claim for eligibility or benefits under the Citigroup Health Benefits Plan; in such an event, coverage may be terminated retroactively.

You and your eligible covered dependents may be able to continue coverage under COBRA. See "COBRA" beginning on page 41.

Coverage When You Retire

You could be eligible for retiree health care coverage if:

- Your age plus completed years of service with Citi totals at least 60; and
- You have attained age 50 and have at least five years of Citi service.

Note: If you are eligible for retiree health coverage and you have attained age 65, you will be assisted by Via Benefits a Willis Towers Watson Company, to enroll in Medicare exchange health care coverage. For information on Via Benefits and health plan and premium options, call Via Benefits at **1 (888) 427-8835**.

For more information about eligibility for retiree health plan coverage and the cost of coverage, call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

A Note for Employees Who Were Involuntarily Terminated

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

1. The date you would have met the age and service requirements for retiree health plan eligibility had you remained employed;

2. If you elected COBRA, at any time during your COBRA continuation period after you have met such age and service requirements; or
3. If you elected COBRA, at the end of such COBRA period. *If you do not enroll in retiree health coverage at or before the end of your COBRA period, you'll waive all rights to future enrollment in Citi's retiree health plan coverage.*

Alternatively, if (a) you are eligible for coverage under the U.S. Separation Pay Plan and (b) you are projected to meet the age and service requirements for retiree health coverage eligibility within 12 months after your termination date, but you choose not to enroll in Citi COBRA coverage upon your termination, you will later have a one-time opportunity to enroll in Citi's retiree health plans, as currently available, at the time you meet the age and service requirements for Citi's retiree health plans, determined as if you had remained employed with Citi through such date. If you are involuntarily terminated, and you are eligible for the retiree health plans on your termination date, you must choose between electing retiree health coverage, as currently available, or continuing health coverage through COBRA. If you elect COBRA, you won't be able to elect retiree health coverage at a later date.

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

The Citi retiree health plan, as currently available, permits an eligible retiring employee to enroll in the retiree health plans. However, eligible retiring employees who have attained age 65 will be assisted by Via Benefits to enroll in Medicare health coverage.

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

Coverage if You Become Disabled

You and your eligible dependents may continue medical, dental and vision coverage for up to 13 weeks as long as you make the active employee contributions. You may also continue to participate in the HCSA or LPSA for 13 weeks or if a COBRA election is made, until the end of the calendar year in which your employment ends. After a total of 52 weeks of disability, which includes both STD and LTD leave, generally, your employment may be terminated.

After the 13-week paid STD period, the Citi Benefits Center will bill you for your benefits, where applicable. The cost is not deducted from your LTD benefit.

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

<table>
<tr><th>Plan</th><th colspan="2">Coverage Provisions</th></tr>
<tr><td rowspan="6">Medical</td><td colspan="2">Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions.
If you became disabled prior to January 1, 2014:
If your disability extends beyond 52 weeks, you may continue medical coverage for the lesser of the length of your disability or the medical continuation period, based on your years of service (as shown below).
For the purposes of the Disability Plan, a year of service is each 12 months of service, counting any part of a month in which you provided service. Service before a break in service will be allowed (or not) under the Plan rules. In no event will the time between your periods of Citi service be counted.</td></tr>
<tr><td>Years of Citi service (as of the LTD effective date)</td><td>Medical continuation period after week 52 (the termination of your employment)</td></tr>
<tr><td>Less than two years</td><td>Six months</td></tr>
<tr><td>Two years to less than five years</td><td>Equal to your length of service</td></tr>
<tr><td>Five years or more</td><td>As long as you are deemed disabled and eligible for LTD benefits under the Plan</td></tr>
<tr><td colspan="2">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.</td></tr>
</table>

<table>
<tr><th>Plan</th><th>Coverage Provisions</th></tr>
<tr><td></td><td>
If you became disabled on or after January 1, 2014, and

You commence short-term disability benefits;
You receive disability benefits for 52 weeks (including LTD benefits); and
Your employment is terminated,

you will be eligible to pay the same rate that active employees pay for medical coverage for up to 36 months after your employment terminates, regardless of your years of service with Citi.
At the end of the medical continuation period, you may continue coverage through COBRA for up to 29 months, if applicable.
Regardless of the commencement of your disability, the following applies:

The Disability Administrator will medically manage your claim to determine your eligibility to continue in applicable health and welfare benefits at the active employee rate. If you are a totally disabled employee who has been denied LTD benefit due to a pre-existing condition, who did not enroll in or declined automatic enrollment in LTD coverage, or who has reached the maximum benefit under the two-year limitation rule, the Disability Administrator will medically manage your claim, as well.
Once you become disabled for more than 29 months and are approved for Social Security disability or if earlier you become eligible for Medicare because you attained age 65, Medicare will become your primary medical coverage while benefits under the Citi plan become secondary. If you are receiving Social Security disability benefits due to your disability, you will be automatically enrolled in Medicare Parts A and B when you satisfy the eligibility requirements, unless you decline Medicare Part B coverage. There is typically a fee associated with Medicare Part B coverage. You should maintain your Medicare Part B coverage to receive the maximum benefit under the Citi medical coverage because Citi will pay benefits as if you are enrolled in Medicare Parts A and B. In addition, you may incur penalties if you enroll in Medicare Part B after you are initially eligible.

</td></tr>
<tr><td>Dental</td><td>Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.</td></tr>
<tr><td>Vision</td><td>Coverage will continue for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. Then you may continue coverage under COBRA.</td></tr>
<tr><td>Basic Life and Basic AD&D insurance</td><td>Coverage stops after 52 weeks, but you can convert your Basic Life or Basic AD&D by calling the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. See the For More Information section for detailed instructions, including TDD and international assistance.</td></tr>
<tr><td>GUL insurance</td><td>
Coverage will continue at the active group rate for 52 weeks, including the 13-week period of STD, as long as you pay the active employee contributions. After that, you may continue GUL insurance by paying MetLife directly. MetLife will bill you at the active employee rate for a length of time based on your years of service as shown in the table below:
<table>
<tr><th>Years of Citi service (as of the LTD effective date)</th><th>GUL continuation period after week 52 (the termination of your employment)</th></tr>
<tr><td>Less than two years</td><td>Six months</td></tr>
<tr><td>Two years to less than five years</td><td>Equal to your length of service</td></tr>
<tr><td>Five years or more</td><td>As long as you are deemed disabled and eligible for LTD benefits under the Plan</td></tr>
</table>
Afterward, MetLife will bill you at a higher rate than the Citi group rate. The higher rate will become effective the month following the termination of your active rate coverage based on your years of Citi service noted above. MetLife will send you information regarding the continuation of these coverages when you are required to pay the higher rate.
</td></tr>
<tr><td>Supplemental AD&D insurance</td><td>Your Supplemental AD&D coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits. You can continue your Supplemental AD&D coverage by paying MetLife directly at the higher, portable rate. For additional information, contact MetLife at 1 (888) 252-3607.</td></tr>
<tr><td>Business Travel Accident/Medical (BTA/BTM) insurance</td><td>Coverage stops after 52 weeks, but you can convert your BTA coverage to an individual Accidental Death and Dismemberment (AD&D) policy if you are under age 70 by calling the Citi Benefits Center through ConnectOne at 1 (800) 881-3938. The coverage under the individual policy must be for at least $25,000 and cannot be more than the greater of the amount of your employee coverage or $500,000. See the For More Information section for detailed instructions, including TDD and international assistance.</td></tr>
</table>

Plan	Coverage Provisions
Health Savings Account (HSA)	If you establish an HSA in connection with your High Deductible Health Plan (HDHP) coverage, participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may choose to make additional contributions, on an after-tax basis, directly to your HSA by contacting ConnectYourCare. Such contributions up to the permissible limit are tax-deductible. Any remaining balance in your HSA is yours to take with you when you leave Citi. **Note:** You are no longer eligible to make contributions to an HSA once you enroll in Medicare. You must remain in the HDHP to continue to be eligible to make HSA contributions.
Health Care Spending Account (HCSA)	Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment terminates. You will have until June 30 of the following calendar year to submit and resolve your claims. **Note**: If your 2019 claims deadline falls within the COVID-19 Outbreak Period, your deadline will be recalculated to allow an additional 4 months to submit claims for reimbursement from the end of the Outbreak Period.
Limited Purpose Health Care Spending Account (LPSA)	Participation will continue for the 13-week period of STD as long as you pay the active employee contributions. Then you may continue coverage on an after-tax basis under COBRA for the remainder of the calendar year in which your employment was terminated. You will have until June 30 of the following calendar year to submit and resolve your claims **Note**: If your 2019 claims deadline falls within the COVID-19 Outbreak Period, your deadline will be recalculated to allow an additional 4 months to submit claims for reimbursement from the end of the Outbreak Period.
Dependent Day Care Spending Account (DCSA)	Participation ends on your first day of STD. When you return to work from your approved disability, if you want coverage through the end of the year, you must re-enroll within 31 days of your return. Once re-enrolled, you can incur expenses through the end of the calendar year and will have until June 30 of the following calendar year to submit claims. You cannot be reimbursed for claims incurred while you were on a leave. With the exception of a military leave of absence, you cannot continue DCSA during a leave of absence. **Note**: If your 2019 claims deadline falls within the COVID-19 Outbreak Period, your deadline will be recalculated to allow an additional 4 months to submit claims for reimbursement from the end of the Outbreak Period.
Transportation Reimbursement Incentive Program (TRIP)	Coverage ends on your first day of STD. Your payroll deductions will stop. When you return to work from your approved disability, you can re-enroll, and the TRIP rules apply.
MetLife Legal Plans	Your MetLife Legal Plans coverage will continue until the last day of the month in which you have received your 52nd week of disability benefits, including the 13-week period of STD. You must pay premiums upfront directly to MetLife Legal in order to continue MetLife Legal Plans coverage while on LTD (up to 39 weeks). After your 52nd week of disability, you can continue your coverage for an additional 12 months by paying the full balance of premiums upfront to MetLife Legal for the number of months (not to exceed 12 months) that you would like to retain the MetLife Legal Plans coverage.

Coverage for Surviving Spouse/Partner and/or Dependents

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

If the Employee Was Not Eligible for Retiree Health Plan Coverage at the Time of Death

After a death is reported to the Citi Benefits Center, the surviving spouse/partner and/or dependent children will automatically be enrolled in six months of free medical and/or dental coverage. Before the end of the six-month period, your surviving spouse/partner and/or dependent children will receive a COBRA notification package. They must elect, if they want to continue, the COBRA continuation coverage by signing and returning the election form to the Citi Benefits Center within the election period. See "COBRA" beginning on page 41.

If the Employee Was Eligible for Retiree Health Plan Coverage at the Time of Death

At the end of the free six-month period, as explained above, covered individuals can either continue COBRA coverage or elect retiree health plan coverage, as currently available. Retiree health plan coverage is provided on the same terms as coverage provided to a retired employee.

If the surviving spouse/partner was not enrolled in active employee coverage at the time of the employee's death, he or she is eligible for retiree health plan coverage, as currently available, but not COBRA coverage.

Continuing Coverage

During a Family and Medical Leave Act (FMLA) Leave

FMLA entitles an eligible employee to take a job-protected leave for specified family and medical reasons such as for your own serious health condition; to care for a spouse/partner, child or parent who has a serious health condition; or for your child's birth or placement with you for adoption or foster care.

Consult the Citi Employee Handbook for details of the FMLA policy, including eligibility, duration and compensation related to your leave.

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

If you take an unpaid leave of absence that qualifies under the FMLA, you may continue medical, dental and vision coverage for yourself and your spouse/partner and/or dependent children and continue participating in the Health Care Spending Account (HCSA) or Limited Purpose Health Care Spending Account (LPSA) as long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during a leave are made on an after-tax basis. You will be billed directly for them, and failure to pay the billed amount will result in a loss of coverage.

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, vision and HCSA or LPSA coverage.

If you continue coverage during an FMLA leave, you will have access to the entire amount of your HCSA or LPSA annual election, less any reimbursements you have received. If you stop contributing, your participation in the HCSA or LPSA will be terminated while you are on an FMLA leave. In that case, you may not be reimbursed for any health care expenses you incur after your coverage was terminated.

If your HCSA or LPSA participation is terminated during a paid leave and you return to work during the same year in which your leave began, your contributions will resume. You can choose to resume contributions at the same level in effect before your paid FMLA leave or elect to increase your contribution level to make up for the contributions you did not make during your leave. If your HCSA or LPSA participation is terminated during an unpaid leave, your contributions will not resume when you return to work. However, you may elect to begin contributing to the HCSA or LPSA, providing you are eligible, when you return to work following an unpaid leave. You must re-enroll within 31 days of your return.

If you resume your prior contribution level, then the amount available for reimbursement for the year will be reduced by the contributions you missed during the leave.

Regardless of whether you choose to resume your prior contribution level or to make up missed contributions, you cannot use your HCSA or LPSA for expenses incurred during the period in which you did not participate.

Coverage if You Take an Unpaid Leave of Absence

If you go on an approved leave of absence, you may continue coverage under the medical, dental, vision and HCSA or LPSA. Your reduction in hours (less than 20 hours per week) constitutes a COBRA-qualifying event under the plans. See "COBRA" beginning on page 41 regarding continuation of coverage.

Call the Citi Benefits Center through ConnectOne about your rights to continue medical, dental, vision and HCSA or LPSA coverage. You will be billed directly for this coverage, and failure to pay the billed amount will result in a loss of coverage. Call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Continuing Coverage during a Military Leave of Absence – Citi Policy

The Citigroup Paid Military Leave of Absence Policy is updated from time to time. For the latest copy of the policy, visit **www.citigroup.net** (intranet only). 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 of absence — whether for active duty or for training — you are entitled to continue your medical, dental, vision, DCSA, and HCSA or LPSA 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 insurance 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 Citi Benefits Center to enroll in or stop coverage. If you do not contact the Citi Benefits Center, your benefit elections will continue in effect for the remainder of the year in which you are on a military leave with the exception of:

- Transportation Reimbursement Incentive Program (TRIP) participation, which stops automatically when your leave begins; and
- Short-Term Disability (STD), Long-Term Disability (LTD) and Business Travel Accident/Medical (BTA) insurance, which are suspended automatically when your leave begins.

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 insurance benefit plans. If you elect to discontinue coverage while on a leave, you will have the right to re-enroll when you return to work.

If you are a reservist called to active military duty for more than 179 days, you are entitled to receive a taxable distribution of your HCSA or LPSA balance (contributions less the amount reimbursed) if you request a distribution by the last day of the calendar year in which you made such contributions.

Call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance. You can also contact your HR representative for more information about a military leave of absence.

Continuing Coverage during Military Leave —Federal Policy Applicable if No Citi Policy

In the event Citi's Paid Military Leave of Absence Policy expires or otherwise ceases to remain in effect, you are still entitled to continue coverage for yourself and your eligible dependents under the Citigroup Health Benefits Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and the HCSA or LPSA under the Citigroup Spending Account Plan for the length of your leave up to 24 months in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as long as you give Citi notice of your leave as soon as practical (advance notice, if possible). Your contributions would be made on an after-tax basis.

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

If you take a military leave, but your coverage under the Plans is terminated, for instance, because you do not elect the extended coverage, you will be treated as if you had not taken a military leave upon re-employment when the Plan Administrator determines whether an exclusion or waiting period applies once you are reinstated to the Plans. The Plan Administrator may take other steps to administer the Plans in accordance with USERRA and Department of Labor regulations.

If you are on a military leave for fewer than 24 months and you do not return to work at the end of your leave, you may be entitled to purchase COBRA continuation coverage. Your eligibility for COBRA will begin on the date your leave ends. Call the Citi Benefits Center or contact your HR representative for more information about a military leave. For the Citi Benefits Center, call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), requires that most employers sponsoring group health plans offer to employees, their spouses and eligible dependents the opportunity for a temporary extension of health coverage (called “continuation coverage”) at group rates in certain instances (called “qualifying events”) where coverage under the plan would otherwise end. The Citi plans that are subject to COBRA are the Citigroup Health Benefits Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and the health care spending accounts (HCSA/LPSA) under the Citigroup Spending Account Plan (collectively the “Health Plans”). Federal law does not require it, but Citi provides coverage similar to COBRA to partners of employees as well.

Eligibility to elect COBRA coverage is contingent upon the Health Plan in which you were enrolled as an active employee prior to the qualifying event.

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.

Citi reserves the right to terminate your coverage retroactively if you are determined to be ineligible under the terms of the Health Plans.

You must pay the entire contribution (employee plus employer cost) plus a 2% administration fee for your continuation coverage. A grace period of at least 60 days applies to the payment of the regularly scheduled contribution.

Note: You may have options other than the COBRA continuation of health benefits available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. The day after your employment terminates and you are ineligible for coverage under the Citi health plan, there is a 60-day special enrollment period during which you can enroll for coverage in the Health Insurance Marketplace. If you are considering enrolling for coverage under the Exchange, be mindful of this enrollment deadline.

Who Is Covered under COBRA

You have a right to choose this continuation coverage if:

- You are enrolled in the Citigroup Health Benefits Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or HCSA or LPSA 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 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; (b) the date that you do not return to work after the leave; or (c) the last day of the FMLA leave period.

If you are the spouse/partner of an employee and are covered by the Citigroup Health Benefits Plan, the Citigroup Dental Benefit Plan or the Citigroup Vision Benefit Plan (or your claims can be reimbursed through your spouse’s/partner’s HCSA or LPSA) and you lose coverage under a Citi-sponsored group health plan for any of the following four reasons on the day before the qualifying event, you are a qualified beneficiary and have the right to elect continuation coverage for yourself:

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

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

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 Citi-sponsored medical, dental or vision plan or HCSA or LPSA.

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 plans and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to Citi of the birth or adoption.

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

Separate Elections

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

Electing COBRA

To inquire about COBRA coverage, speak to a Citi Benefits Center representative. Call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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

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

Important COVID-19-Related Updates

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

- **Notification Deadline Extension**: If you have a COBRA-qualifying event and your initial or secondary qualifying event deadline falls within the National Emergency and you are required to provide notice related to the qualifying event, you have up to the Agencies' deadline noted above to notify the Plan.
- **Enrollment Deadline Extension**: If you become eligible for COBRA, you have a 60-day initial enrollment period. If your enrollment deadline falls within the National Emergency, you have up to the Agencies' deadline noted above to enroll in COBRA.

Under the American Rescue Plan Act of 2021, employers must pay 100% of COBRA premiums from April 1, 2021 through the end of September 2021 (the “Subsidy Period”) for all “assistance eligible individuals”.

“Assistance eligible individuals” means qualified beneficiaries:

- whose qualifying event is an involuntary termination of employment or reduction in hours;
- who are not otherwise eligible for Medicare or other group health plan coverage (other than excepted benefits, HCSA or LPSA);
- who were enrolled in medical, dental or vision coverage prior to termination; and
- whose last day of coverage was April 1, 2021 or later.

All other qualified beneficiaries, including those based on voluntary terminations of employment, are not eligible for the COBRA premium subsidy and may be subject to a penalty if the subsidy is received while ineligible. This COBRA premium subsidy does not apply to the HCSA and LPSA.

Duration of COBRA

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

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

Additional qualifying events may occur while the continuation coverage is in effect after an initial qualifying event, such as loss of employment. Examples of such events are the death of the covered employee, divorce, legal separation, the covered employee becoming entitled to Medicare, or a dependent child’s loss of dependent status.

If you lose coverage because of a termination of employment or a reduction in hours, these events can, but do not always, result in an extension of an 18-month continuation period to 36 months for your spouse/partner and dependent children. However, in no event will COBRA coverage last beyond 36 months from the date of the event that originally allowed a qualified beneficiary to elect such coverage. You must notify the Citi Benefits Center if a second qualifying event occurs during your continuation coverage period. Call ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

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

Special Rule for HCSA and LPSA

Generally, unless required by law, continuation coverage for HCSA and LPSA will not be available beyond the end of the year in which the qualifying event occurs. For more information, please see the *Spending Accounts* section.

Special Rules for Disability

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

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

Medicare

If, within 18 months after becoming entitled to Medicare, you subsequently lose Health Plan coverage 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.

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

1. Citi 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 the 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 SSA makes a final determination that the individual is no longer disabled.

COBRA and FMLA

A leave that qualifies 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 Citi that you are not returning to work at the end of the leave; or

> The end of the leave, and you do not return to work.

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

> You or your spouse/partner and/or dependent child is covered by the applicable Health Plans on the day before the leave begins; and

> You do not return to work at the end of the FMLA leave.

Your Duties

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

- A divorce or legal separation;
- The loss of a child's dependent status under the applicable Health Plans;
- An additional qualifying event (such as a death, divorce or legal separation) that occurs during the employee's or family member's initial continuation coverage period of 18 (or 29) months;
- A determination by the SSA that the employee or family member was disabled at some time during the first 60 days of an initial continuation coverage period 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 Citi during this notice period, any individual(s) who loses coverage will not be offered the option to elect continuation coverage.

The notice may 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.

Mail this information to the address below if the covered person is an active employee of Citi:

Citi Benefits Center
2300 Discovery Drive
PO Box 785004
Orlando, FL 32878-5004

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

Citi's Duties

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

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

Cost of COBRA Coverage

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

The cost of group health coverage periodically changes. If you elect continuation coverage, Citi will notify you of any changes in the cost. If coverage under the applicable Health Plan(s) is modified for similarly situated non-COBRA beneficiaries, the coverage made available to you may be modified in the same way. You and your family members will be subject to these changes in the cost of coverage.

The initial payment for continuation coverage is due 60 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis for which you have a grace period of at least 60 days.

Important COVID-19-Related Changes that Extend COBRA Payment Deadlines

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

If enrolled in COBRA, you have 60 days to submit payment for your initial bill and 60 days to submit payment for subsequent bills. For payment deadlines that fall within the defined National Emergency, you will generally have a 60-day grace period subject to the Agencies' deadline (as defined above) to submit your payments. While the length of time you have to submit you COBRA payment is extended, the amount owed for applicable months of coverage will remain the same. If the full amount owed is not submitted by the extended deadline, coverage will be terminated retroactively to the last day of the month for which you have made payment.

If you have any questions about COBRA coverage or the application of the law, contact the COBRA Administrator at the address below. If the covered person has terminated employment with Citi and your marital status has changed, or you or a qualified beneficiary has changed addresses, or a dependent ceases to be a dependent eligible for coverage under the terms of the Health Plan(s), you may notify the COBRA Administrator in writing immediately at the address below.

All notices and other communications regarding COBRA and Citi-sponsored Health Plans should be directed to:

Citi Benefits Center
2300 Discovery Drive
PO Box 785004
Orlando, FL 32878-5004

You may also call the Citi Benefits Center through ConnectOne at **1 (800) 881-3938**. See the *For More Information* section for detailed instructions, including TDD and international assistance.

Coordination of Benefits

All payments under these plans will be coordinated with benefits payable under any other group benefit plans that provide coverage for you or your dependent(s). Coordination of benefits prevents duplication of payments when a covered employee or a covered dependent has health coverage under a Citi Plan and one or more other plans, such as a spouse's/partner's or other employer's plan.

The Citigroup Health Benefits Plan (which includes prescription drug coverage), the Citigroup Dental Benefit Plan and the Citigroup Vision Benefit Plan ("Citi Plans") contain a coordination-of-benefits provision that may reduce or eliminate the benefits otherwise payable under the applicable plan when benefits are payable under another plan. Certain provisions are summarized below, and additional terms and conditions may apply under the terms of the other sections of this Benefits Handbook.

The following definitions apply to terms used in this section:

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

When you are covered by more than one plan, the primary plan will pay benefits first, while the secondary plan will pay benefits after the primary plan has paid benefits.

How Coordination of Benefits Works

- **When the Citi Plan is primary:** The Citi Plan considers benefits as if a secondary plan does not exist, and it will pay benefits first. Benefits will be calculated according to the terms of the applicable plan and will not be reduced due to benefits payable under other plans.
- **When the Citi Plan is secondary:** The Citi Plan will pay the difference, if any, between what you would have received from Citi if it were the only coverage and what you are eligible to receive from the other plan. Total benefits will never equal more than what the Citi Plan would have paid alone. Benefits under the Citi Plan may be reduced. The Claims Administrator will determine the amount the Citi Plan normally would pay. Then the amount payable under the primary plan for the same expenses will be subtracted from the amount the Citi Plan would have normally paid. The Citi Plan will pay you the difference. If the Citi Plan is secondary, you will never be paid more for the same expenses under both the Citi Plan and the primary plan than the Citi Plan would have paid alone.

  When the Citi Plan is secondary and the patient is covered under an HMO, benefits under the Citi Plan will be limited to the coinsurance, if any, for which you would have been responsible under the HMO, whether or not the services provided are rendered by the HMO. If a service is not covered or coverage is denied, you will be responsible for payment.

Aetna and Anthem BlueCross BlueShield: With regard to automobile accidents, this plan **always** pays secondary to:

- Any motor vehicle policy available to you, including any medical payments, personal injury protection (PIP) and no-fault; and
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

The Citi Plan will be the primary plan for claims:

- For you, if you are not covered as an employee by another plan;
- For your spouse/partner, if your spouse/partner is not covered as an employee by another plan; and
- For your dependent children, if they are not covered by another plan through their employment or through military service.

Parents' birthdays are used to determine whose coverage is primary for the children. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered primary coverage. For example, if your spouse's birthday is in January and your birthday is in May, your spouse's plan is considered the primary plan for your children.

If both parents have the same birthday, then the coverage that has been in effect the longest is primary. This rule applies only if the parents are married to each other.

In Case of Divorce or Legal Separation

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

1. The plan of the parent with custody of the child;
2. The plan of the spouse of the parent with custody of the child; and
3. The plan of the parent who does not have custody of the child.

In the event of a legal conflict between two plans over which is primary and which is secondary, the plan that has covered the individual for the longer time will be considered primary. When a plan does not have a coordination-of-benefits provision, the rules in this provision are not applicable, and such plan's coverage is automatically considered primary.

Coordination with Medicare

When you or your eligible dependents are entitled to Medicare and you are covered under the Citi Plan as an active employee, the Citi Plan continues to be the primary plan. The Citi Plan is primary for the following situations:

- Eligible active employees age 65 and over who are entitled to Medicare benefits;
- Dependent spouses age 65 and over who participate in the Citi Plan on the basis of the current employment status of the employee and who are entitled to Medicare benefits; and
- For the first 30 months of Medicare entitlement, certain individuals who become eligible for Medicare on the basis of having end-stage renal disease (ESRD). After this initial 30-month period, the Citi Plan is secondary to Medicare.

If you or a covered family member becomes covered by Medicare *after* a COBRA election is made, your COBRA coverage may end. Medicare is the primary plan if you are enrolled in COBRA.

If you or your dependent is eligible for Medicare, and you are no longer an active employee, enrollment in Medicare cannot be deferred based on enrollment in COBRA. Delaying enrollment in Medicare beyond initial eligibility may result in the assessment of penalties or late fees.

No-fault Automobile Insurance

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

Facility of Payment

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

Right of Recovery

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

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

Aetna and Anthem BlueCross BlueShield: With regard to automobile accidents, this Plan **always** pays secondary to:

- Any motor vehicle policy available to you, including any medical payments, PIP and no-fault; and
- Any plan or program which is required by law.

All covered persons should review their automobile insurance policy and ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer. For more information, please see "Recovery Provisions "in the *Administrative Information* section.

Release of Information

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

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

Cross-Plan Offsets

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive (an "Overpayment"), the Plan has the right to be repaid. The Plan has the right to reduce by the amount of the Overpayment, any future benefit payment made to you or your dependents. The Plan may also recover Overpayments by reducing future payments to a provider by the amount of the Overpayment under a process referred to as a "cross-plan offset." These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator(s) ("TPA"). Under this process, the TPA reduces future payments to providers by the amount of the Overpayments they received, and then credits the recovered amount to the plan that made the overpayment.

How to File a Claim

Need Help Resolving a Claim Issue?

Health Advocate can help: call **1 (866) 449-9933**. For more information about Health Advocate, visit Live Well at Citi.

Claims must be submitted in order to receive reimbursement for charges incurred under the Plans. Many times, the claim is submitted electronically to the Claims Administrator without your intervention needed. However, you may be required to manually submit a claim for expenses to be paid or approved for reimbursement. Keep in mind that you cannot submit medical, dental, vision, HCSA, LPSA or DCSA claims for services or expenses incurred prior to the effective date of your coverage.

Listed below are the forms needed to claim benefits that may not be reimbursed automatically or paid directly. Claims should be sent to the Claims Administrators as detailed under "Claims Administrators" in the *Administrative Information* section. If you do not receive benefits to which you believe you are entitled, see the applicable "Claims and Appeals" subsection in the section that describes each plan at **handbook.citibenefitsonline.com**, available from the Citi intranet and the Internet. No password is required.

Name of Plan	Name/Form Number and When to Use the Form	How to Obtain a Form
Aetna > Choice Plan 500 (CP500) > High Deductible Health Plan (HDHP)	Aetna Medical Benefits Request form Use the form to file a claim for covered out-of-network expenses.	Visit Forms and Claims at Citi Benefits Online at **www.citibenefits.com** Or Visit Your Benefits Resources™ through My Total Compensation and Benefits at **www.totalcomponline.com**
Anthem BlueCross BlueShield > CP500 > HDHP	Anthem BlueCross BlueShield Claim form Use the form to file a claim for covered out-of-network expenses.	
HMOs	Call your HMO for any claim-filing information. Use the contact information on the back of your ID card or see the *For More Information* section.	
CVS Caremark (Prescription drug coverage for CP500 and HDHP)	CVS Caremark Prescription Drug Claim form Use the form to file a claim for covered out-of-network expenses.	Visit Forms and Claims on Citi Benefits Online at **www.citibenefits.com** Or Visit Your Benefits Resources™ through My Total Compensation and Benefits at **www.totalcomponline.com** Or Call CVS Caremark at **1 (844) 214-6601** or visit **www.caremark.com**
MetLife Dental PDP	MetLife Dental Claim form Use the form to file a claim for covered dental expenses.	Visit Forms and Claims on Citi Benefits Online at **www.citibenefits.com**
Cigna DHMO	There are no claim forms required with the Cigna Dental HMO plan. When your Dental Patient Charge Schedule lists a copay, pay that amount to the dentist directly after you receive care.	
Vision Plan	Aetna Vision Claim form Use the form to file a claim for covered out-of-network expenses.	Visit Forms and Claims on Citi Benefits Online at **www.citibenefits.com** Or Visit **www.aetnavision.com**
Health Care Spending Account (HCSA)	HCSA/LPSA Claim form Use the form to submit eligible health care claims for reimbursement if you do not use the ConnectYourCare Payment Card	Visit the ConnectYourCare (CYC) website through My Total Compensation and Benefits at **www.totalcomponline.com** Or Visit Forms and Claims on Citi Benefits Online at **www.citibenefits.com**
Limited Purpose Health Care Spending Account (LPSA)	HCSA/LPSA Claim form Use the form to submit eligible vision, dental, and/or preventive care health care claims for reimbursement.	
Dependent Day Care Spending Account (DCSA)	DCSA Claim form Use the form to submit eligible dependent care claims for reimbursement.	

Name of Plan	Name/Form Number and When to Use the Form	How to Obtain a Form
Transportation Reimbursement Incentive Program (TRIP)	TRIP Claim form **Note:** With the exception of the Parking Cash Reimbursement Option (CRO), all other TRIP CRO claims must be filed within 12 months from the date of service. Parking Cash Reimbursement Option (CRO) claims must be filed by June 30 following the year in which the expense was incurred.	
MetLife Legal Plans	MetLife Legal Plans Out-of-Network Claim Form **Note**: You do not need to file a claim when you use an in-network attorney.	Contact MetLife Legal Plans at (800) 821-6400 to request an out-of-network claim form. You will be reimbursed according to a set fee schedule.

All claims for benefits and pertinent supporting documents must be filed by these deadlines:

- Medical, dental and vision claims must be filed within two years of the date of service. If you participate in an HMO, call your HMO for its claim-filing deadlines.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA, LPSA and DCSA claims must be filed and resolved (i.e., all substantiating documentation should be submitted) by June 30 following the year in which the expense was incurred.
- TRIP Parking Cash Reimbursement Option (CRO) claims must be filed by June 30 following the year in which the expense was incurred.

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

On May 4, 2020, the U.S. Departments of Labor and the Treasury (the Agencies) issue guidance that temporarily extends the deadlines in place for certain benefit changes and processes associated with election, notification, payment and claims/appeals in connection with the Coronavirus disease of 2019, which was deemed a national emergency on March 1, 2020 (the National Emergency). To protect individuals from losing benefit, the Agencies extended deadlines that might have been missed during the National Emergency. The temporary extension of the deadlines was initially set to expire 60 days after the end of the National Emergency. The Agencies have revised their guidance to provide that your extended deadline will end on the earlier of one year from your original deadline or your original time limit after the end of the National Emergency as described above (Agencies' deadline).

For HCSA, LPSA, and DCSA claims: The deadline to submit any claims for expenses incurred during 2019 has been recalculated to allow an additional four months to submit claims for reimbursement from the end of the Agencies' deadline.

For more information, contact the Claims Administrators as detailed under "Claims Administrators" in the *Administrative Information* section, or call the Citi Benefits Center via ConnectOne at **1 (800) 881-3938** for additional help. From the Benefits menu, select the appropriate option. See the *For More Information* section for detailed instructions, including TDD and international assistance.