Disability Coverage

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

This section describes the STD and LTD benefits available. The receipt of STD and LTD benefits is subject to the terms and conditions of the applicable Plan. For complete details about your coverage under the LTD Plan, see the insurance certificate, which is also part of the Plan, at Citi Benefits Online. If there is any discrepancy between the provisions in this section of the Handbook and the related insurance certificate provided by the insurance company, the provisions of the insurance certificate shall prevail.

If you do not have access to the Citi intranet or the Internet, you can request a copy of the certificate at no cost to you by speaking with a Citi Benefits Center representative. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "health and welfare benefits" option.

Definition of years of service for the Plan (STD and LTD benefits)

For purposes of the Disability Plan, your years of service are based on your actual time providing services to Citi as an employee. You are credited with service from your hire date, or if you have had one or more breaks in service, from your adjusted service date. You will have a year of service for this purpose for each 12 months of service, counting any part of a month in which you provided service.

Service before a break in service will be allowed (or not) under rules similar to the Citigroup Pension Plan credited service rules, such as not counting service prior to five consecutive one-year breaks in service. In no event will the time between your periods of Citi service be counted.

Managed Disability Brochure

To learn more about how to report a disability and what happens to your benefits coverage while you are on a leave of absence, see the Managed Disability brochure at **www.citibenefitsonline.com/citi-managed-disability-brochure.pdf.**

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Short-Term Disability (STD)

The STD benefit is a core benefit available to all benefits-eligible employees. No enrollment is necessary. However, you must report all disabilities to the Claims Administrator before you can receive a benefit. To report your disability, call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "disability" option. You also can call MetLife, Citi's disability claims administrator, directly at **1-888-830-7380**. For a complete description of your responsibilities and those of MetLife when you report a disability, see the Managed Disability brochure at **www.citibenefitsonline/citi-managed-disability-brochure.pdf**.

STD pays 100% or 60% of base salary (not benefits eligible pay) during an approved disability of up to 13 weeks based on your years of service. For employees hired or rehired on or after January 1, 2011, there is a 90-day waiting period before disability benefits are payable (as shown in the following schedules of benefits).

STD schedule of benefits – Benefits-eligible salaried employees			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of base salary**
Less than 90 days	0	0	0
90 days to less than 1 year	1	12	13
1 year to less than 2 years	4	9	13
2 years to less than 3 years	6	7	13
3 years to less than 4 years	8	5	13
4 years to less than 5 years	10	3	13
5 or more years	13	0	13

STD schedule of benefits – ICG and CPWM employees that hold the title of Financial Advisor ("FA") or its equivalent and receive commissions as a component of their benefits eligible pay			
Years of service	**Minimum benefit (% of benefits eligible pay)**	**Plus additional benefit**	**Maximum benefit (% of benefits eligible pay)**
Less than 90 days	0	0	0
90 days to less than 3 years	60%	Commissions	100%
3 years to less than 7 years	70%	Commissions	100%
7 or more years	80%	Commissions	100%

Paid Pregnancy Leave – Benefits-eligible salaried employees			
Years of service	**Weeks at 100% of base salary**	**Weeks at 60% of base salary**	**Total weeks of benefit**
Less than 90 days	0	0	0
90 days to less than 1 year	1	12	13
1 or more years	13	0	13

Paid Pregnancy Leave – ICG and CPWM employees that hold the title of Financial Advisor ("FA") or its equivalent and receive commissions as a component of their benefits eligible pay			
Years of service	**Minimum benefit (% of benefits eligible pay)**	**Plus additional benefit**	**Maximum benefit (% of benefits eligible pay)**
Less than 90 days	0	0	0
90 days to less than 1 year	70%	Commissions	100%
1 or more years	80%	Commissions	100%

For non-salaried employees: The STD benefit will be calculated by your business but will not exceed 100% of your benefits eligible pay for benefits purposes.

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

When STD benefits are payable

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

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

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

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

STD benefits are taxable as ordinary income. Citigroup will withhold taxes, as well as deductions for other employee benefits, from STD benefits.

Short-term disability benefits may be offset by any monies owed to Citi and/or by any state benefits, including Worker's Compensation and Social Security disability benefits. However, the Plan does not subrogate short-term disability payments.

Exclusions

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

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

For employees who work in California

If you are eligible for disability benefits, you are covered by the Citigroup California Voluntary Disability Insurance (VDI) Plan (the "VDI Plan"), unless you reject the VDI Plan. The VDI Plan replaces the state plan. For details, ask your HR representative.

If you are covered by the VDI Plan, you are not eligible to file a claim with the state. You must report your disability to MetLife. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu choose the "disability" option. You also can call MetLife directly at **1-888-830-7380**.

Long-Term Disability (LTD)

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

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

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

Participation

Citi provides Company-paid LTD coverage to employees whose benefits eligible pay is less than or equal to $50,000.99. If your benefits eligible pay is less than or equal to $50,000.99, you do not need to enroll for coverage and there is no cost to you.

If as a new hire, your benefits eligible pay exceeds $50,000.99, you may be automatically enrolled in LTD coverage with an option to decline coverage.

If your benefits eligible pay increases to $50,001 or above for benefits purposes in the next plan year, you will be automatically enrolled in LTD coverage so your coverage continues uninterrupted. The cost of LTD coverage will be deducted from your pay beginning January 1 of the next plan year (following annual enrollment) unless you decline coverage. Refer to the Your Benefits Resources™ website during annual enrollment for the cost.

If you do not elect "no coverage" during annual enrollment (or as a new hire) you will be automatically enrolled. You have the option to decline coverage. If you do so within the first 90 days following your enrollment, you will receive a refund of your paid premiums. You can also decline coverage after the initial 90-day period, however, premiums will not be refunded to you.

If your benefits eligible pay is:	
$50,000.99 or less*	Citi provides LTD coverage at no cost to you.
From $50,001 to $500,000	You will pay for coverage with after-tax dollars. The LTD benefit under the Citi plan is tax free.

* If your benefits eligible pay increases above $50,000.99 during the year, you will be enrolled in LTD coverage, during annual enrollment, for the following year automatically. Effective January 1 of the following year, contributions will be deducted from your pay. If you do not want LTD coverage for the following year, you must select "no coverage" during annual enrollment. However, if you do not opt out of LTD coverage during annual enrollment you will have 90 days beginning January 1 to opt out. If you opt out within this 90-day period, these contributions will be refunded to you.

Benefits are paid monthly and continue for as long as your approved disability continues, up to age 65 (or longer, depending on your age when your disability begins). See the following schedule.

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

You will be billed for your health and welfare benefits to the extent you are enrolled. The cost of benefits is not deducted from your LTD benefit. For details, see the Managed Disability brochure at www.citibenefitsonline.com/managed-disability-brochure.pdf.

Unless you have other disability coverage, you should consider enrolling in LTD since LTD coverage protects you in the event your ability to work is impaired by an accident or illness.

You do not have to enroll in LTD coverage despite automatic enrollment, as described. However, if you decide to enroll in LTD coverage at any time, other than when first eligible as the result of a qualified change in status, you must take a physical exam and/or provide evidence of good health before coverage will be approved.

Note: The Plan will not cover any disability caused by or contributed to, or resulting from, a pre-existing condition until you have been enrolled in the Plan for 12 consecutive months.

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

Converting your coverage

If you have been enrolled in the Plan for one year and leave Citi (other than to retire), you can convert your Citi LTD coverage under the group policy to an individual policy within 31 days after your employment ends. You could retire if you:

- Terminate employment after your age plus completed years of service with Citi totals at least 60; and
- Have attained age 50; and
- Have at least five years of Citi service.

The maximum benefit of this individual policy is $3,000 per month. To obtain conversion information, call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option.

When LTD benefits are payable

If you are enrolled in LTD coverage (pursuant to the terms of the Disability Plan on your date of hire) and your approved disability continues for more than 13 weeks, you may be eligible for an LTD benefit.

For purposes of initially qualifying for LTD benefits, a disability means that due to sickness, pregnancy, or accidental injury, you are receiving appropriate care and treatment from an attending physician on a continuing basis and are unable to perform your own occupation for any employer in your local economy. Refer to the insurance certificate at Citi Benefits Online for additional details.

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

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

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

Claims and appeals

You should file an STD claim as soon as you know you will be out of work for more than seven consecutive calendar days due to an illness or injury.

To file a claim, call MetLife, the Claims Administrator for the STD Plan, at **1-888-830-7380**; for text telephone service, call **1-877-503-0327**. You can also call ConnectOne at **1-800-881-3938**; from the main menu, choose the "disability" option and follow the prompts to report a disability. The Claims Administrator will provide the appropriate forms and can help you file for state disability benefits, where applicable.

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

- Name, address, telephone number, and Social Security number;
- Manager's/supervisor's name, telephone number, e-mail address, and mailing address;
- Your attending physician's name, address, and telephone number; and
- Information about your illness. **Note:** You should not give specifics, such as a medical diagnosis, for non-work-related injuries or illnesses to your manager/supervisor.

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

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

MetLife, as the fiduciary, is responsible for adjudicating claims for benefits under the Plan and for deciding any appeals of denied claims. The Claims Administrator shall have the authority, in its discretion, to interpret

the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Claims Administrator shall be final and binding on participants and beneficiaries to the fullest extent permitted by law.

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

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

During the review period, the Claims Administrator may require you to have a medical exam, at its own expense or to provide additional information regarding the claim. If a medical exam is required, the Claims Administrator will notify you of the date and time of the exam and the physician's name and location. You should keep the appointment since rescheduling an exam will delay the claim process. If additional information is required, the Claims Administrator must notify you in writing specifying the information needed and explaining why it is needed.

If your claim is approved, you will receive the STD benefit from Citi; the LTD benefit will be paid by the Claims Administrator.

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

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

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

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

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

- The specific reason(s) the appeal was denied;
- Specific reference to the Plan provision(s) on which the denial was based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access and copies of all documents, records, and other information relevant to your appeal for benefits; and
- Identification of any internal rule, guideline, or protocol relied on in making the appeal decision and an explanation of any medically related exclusion or limitation involved in the decision.

In the event that your appeal is denied, you have the right to bring a legal action under Section 502(a) of ERISA; provided, that you file any lawsuit or similar enforcement proceeding, commenced in any forum, relating to the Plan within 12 consecutive months after the date of receiving a final determination on review of your appeal, or if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit. The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to commence suit is specified in an insurance contract forming part of the Plan or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency, as applicable. Generally, the determination reached by the Plan is final.