Insurance benefits

Citi offers various insurance programs for you and your dependents:

- Basic Life insurance, if your benefits eligible pay is less than $200,000;
- Basic Accidental Death and Dismemberment (AD&D) insurance, if your benefits eligible pay is less than $200,000;
- Group Universal Life (GUL) insurance for you and your spouse/civil union partner/domestic partner;
- Supplemental AD&D insurance for you and your spouse/civil union partner/domestic partner;
- Business Travel Accident/Medical insurance;
- Term life and Supplemental AD&D insurance for your children; and
- Long-Term Care insurance (if enrolled prior to 1/1/12).

Insurance benefits are fully-insured. Benefits are provided under the contracts entered into between Citigroup (the “Plan Sponsor”) and the insurers. The insurers, not the Plans Administration Committee of Citigroup Inc. (the “Plan Administrator”) or the Plan Sponsor, administer benefit claims and appeals procedures and are responsible for paying claims.

Did you know?

If you're enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney. Call Hyatt Legal Plans at **1-800-821-6400** and provide the Citi group number 1137000 to get more information.

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Basic Life insurance

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

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

Since Citi pays the full cost of Basic Life insurance, you must pay taxes on the value of the coverage above $50,000 as required by the Internal Revenue Code (the "Code"). The Basic Life insurance benefit that exceeds $50,000 for tax purposes is treated as income to you and is called "imputed income." This imputed income is taxable income to you and is shown on your pay statement and Form W-2 Wage and Tax Statement for the year in which coverage was effective. Imputed income is taxable pay based on your age and the amount of Basic Life insurance coverage above $50,000.

If your benefits eligible pay is more than $50,000, you may elect to limit your Basic Life insurance to $50,000. You will not have imputed income or be subject to the related tax; however, you will also forego the additional benefit. You will not have the opportunity to enroll in Basic Life equal to your benefits eligible pay or to reduce coverage until the next annual enrollment period.

If your benefits eligible pay increases to $200,000 or above

Once your benefits eligible pay is equal to or exceeds $200,000, you are no longer eligible for Basic Life and Basic AD&D. As a result, you may have the opportunity to enroll in Group Universal Life (GUL) coverage (you can enroll in Supplemental AD&D at any time without providing evidence of insurability) equal to one times your benefits eligible pay up to $500,000 *without providing evidence of insurability,* subject to the Plan's maximum coverage limits.

If you are enrolled in GUL up to the maximum coverage amount — the lesser of 10 times your benefits eligible pay or $5 million — you are not eligible to increase GUL coverage. You can convert your Basic Life and AD&D benefits into individual policies. Refer to "Continuing Basic Life and Basic AD&D on an individual basis" on page 268.

Basic Life Accelerated Benefits Option

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

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

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

- A completed Accelerated Benefit Claim form, available from the Citi Benefits Center by calling ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section;
- A signed physician's certification that states you are terminally ill; and
- An exam by a physician of MetLife's choice, if requested, at no expense to you.

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

Basic Accidental Death and Dismemberment (AD&D) insurance

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

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

Naming a beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death.

You may designate or change your beneficiary for Basic Life or Basic AD&D insurance at any time by visiting Your Benefits Resources™ through TotalComp@Citi at **www.totalcomponline.com**.

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

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

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

Continuing Basic Life and Basic AD&D on an individual basis

You can convert your Basic Life coverage to an individual policy after the termination of employment from Citi. You'll receive a Health and Welfare Benefits Conversion/Portability Notice from the Citi Benefits Center once you lose eligibility. Once this is received, you may call MetLife directly at **1-877-275-6387** within 31 days after you become ineligible.

Regarding Basic AD&D insurance, once notified of your loss of eligibility MetLife will send you information on how to continue coverage. Note that rates will be higher than the Citi group rate. If you have any questions about continuing your AD&D on an individual basis, please call MetLife directly at **1-888-252-3607**.

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

Note that the rates for continuing your Basic Life and/or Basic AD&D insurance may be higher than the Citi group rate.

Group Universal Life (GUL) insurance

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

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

If you are enrolling in GUL insurance outside your initial eligibility period (31 days from your date of hire/date you are eligible to enroll in Citi benefits), outside of a qualified change in status, or for an amount greater than three times your benefits eligible pay (capped at $500,000) or $1.5 million, you must provide evidence of insurability and be actively at work before coverage will be effective. “Actively at work” means that you are regularly scheduled to work in the office or at home. You must be able to perform all the activities of your job.

Enrolling in GUL coverage

You will enroll in coverage directly with MetLife, not through Citi. Visit TotalComp@Citi at **www.totalcomponline.com** or submit an enrollment form, which you can obtain by calling MetLife at **1-888-830-7380**. Your spouse/civil union partner/domestic partner must complete a separate enrollment form.

If your benefits eligible pay is reduced, your GUL amount will continue to be based on the higher benefits eligible pay unless you call MetLife at **1-888-830-7380** to request that the GUL amount be reduced. Once you reduce coverage, you can increase it by reinstating the automatic benefits eligible pay or by purchasing additional multiples of your benefits eligible pay. You may be asked to provide satisfactory evidence of insurability before the increased coverage will become effective. GUL coverage for an employee ends at age 95.

If you leave Citi, your GUL coverage may be continued by paying premiums directly to MetLife. MetLife will send you information regarding the continuation of your GUL coverage once notified of your termination or retirement. MetLife will bill you at a higher rate than the Citi group rate. The rate will become effective the month following your termination of employment.

If you are receiving disability benefits from the Citigroup Disability Plan at the time your employment terminates and you are enrolled in GUL coverage, MetLife will bill you at the active employee rate for the same length of time you pay active employee rates for medical coverage, based on your years of service in connection with your disability. Afterwards, MetLife will bill you at a higher rate than the Citi group rate. The rate will become effective the month after you are no longer eligible to pay active employee rates for medical coverage. If you have any questions on continuing your coverage, call MetLife directly at **1-888-830-7380**.

If you continue GUL coverage, you also can continue to contribute to the Cash Accumulation Fund (CAF). If you have a balance in the CAF and do not pay the GUL premiums or notify MetLife that you wish to discontinue the GUL coverage, premiums for the GUL insurance will be deducted from your CAF to keep your coverage active until you notify MetLife that you don’t wish to continue GUL insurance. If you don’t have a CAF account, or your CAF becomes depleted and you don’t pay the premiums to MetLife, your GUL coverage will end.

Did you know?

If you’re enrolled in GUL coverage, you receive Will Preparation and Estate Resolution services at no cost when you work with an in-network attorney. Call Hyatt Legal Plans at **1-800-821-6400** and provide the Citi group number 1137000 to get more information.

GUL Accelerated Benefits Option

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

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

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

- A completed Accelerated Benefit Claim form, available from MetLife by calling **1-888-830-7380**;
- A signed physician's certification that states you are terminally ill; and
- An exam by a physician of MetLife's choice, if requested, at no expense to you.

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

Accelerated benefits are not payable if:

- You have assigned the death benefit;
- All or a portion of your death benefit is to be paid to your former spouse as part of a divorce agreement;
- You attempt suicide or injure yourself on purpose;
- The amount of your death benefit is less than $15,000; or
- You are required by a government agency to request payment of the accelerated benefit so you can apply for, obtain, or keep a government benefit or entitlement.

Cash Accumulation Fund (CAF)

When you enroll in GUL coverage, you can participate in the Cash Accumulation Fund (CAF). The CAF allows you to save money that earns an interest rate at a guaranteed minimum of 4% on a tax-deferred basis. Contributions are deducted from your pay each pay period. The minimum contribution is $10 a month, or $120 a year.

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

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

You can change the amount of your CAF contribution at any time. **Note:** A decrease in your GUL coverage could affect the amount you can contribute to your CAF.

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

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

Taking a loan from your CAF

At any time, you can obtain cash through a loan of at least $200 from your CAF. You may take an unlimited number of loans each plan year, but only one loan can be in effect at any time. The most you can borrow at any time is the current cash value just prior to the loan and less the interest to the next plan anniversary date at the current loan interest rate.

Loan interest is charged at a rate set by MetLife. This rate will never be more than the maximum permitted by law and will not change more often than once a year on the plan anniversary date. Call MetLife at **1-888-830-7380** for the current interest rate.

You may repay all or part of a loan (but not less than $100) at any time while you are alive and enrolled in GUL coverage. Loans are not payable through payroll deductions.

Failure to repay a loan or to pay loan interest will not terminate your GUL coverage unless the balance in your CAF, minus the loan and loan interest, is not sufficient to pay the monthly contribution for GUL coverage. If this occurs, you will be notified that you have a 60-day grace period to pay the amount due.

For more information about CAF loans, call MetLife at **1-888-830-7380**.

Assignment

You may assign your GUL insurance rights and benefits as a gift or as a viatical assignment. In this case, MetLife will recognize the assignee(s) under such assignment as owner(s) of your right, title, and interest if:

- You have completed a written form satisfactory to MetLife affirming this assignment;
- Both you and the assignee(s) have signed the written form;
- The written form has been delivered to MetLife;
- MetLife acknowledges that the life insurance being assigned is in force on your life.

MetLife is not responsible for the validity of an assignment.

Naming a beneficiary

Your beneficiary is the person or persons you choose to receive any benefit payable upon your death. You may designate or change your beneficiary for GUL insurance at any time by calling MetLife at **1-888-830-7380**. You can also visit the MetLife MyBenefits website available through TotalComp@Citi at **www.totalcomponline.com**.

Your spouse/civil union partner/domestic partner must call MetLife at **1-888-830-7380** to name or change a beneficiary.

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

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

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

Coverage for your spouse/civil union partner/domestic partner

You can enroll in GUL insurance coverage, provided by MetLife, for your spouse/civil union partner/domestic partner in increments of $10,000 to a maximum of $100,000. You do not need to buy GUL insurance for yourself to elect coverage for your spouse/civil union partner/domestic partner.

Within 31 days of your initial eligibility, you can enroll for up to $30,000 of spouse/civil union partner/domestic partner GUL coverage without him/her providing evidence of insurability.

If you enroll in GUL coverage at any other time, your spouse/civil union partner/domestic partner must provide evidence of insurability for *any* amount of spouse/civil union partner/domestic partner coverage.

The cost is based on the amount of your spouse's/civil union partner's/domestic partner's coverage, his/her age, and whether he/she has used tobacco products in the past 12 months. You can also contribute to a CAF in his/her name.

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

Life insurance for your children

If you have enrolled in GUL insurance coverage for you or your spouse/civil union partner/domestic partner, you can enroll for life insurance from $5,000 to $20,000, in $5,000 increments, for your eligible dependent children. Life insurance coverage is provided by MetLife. To enroll in child life coverage, call MetLife at **1-888-830-7380** or visit the MetLife MyBenefits website available through TotalComp@Citi at **www.totalcomponline.com**.

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

Separately, you must report the birth or adoption of each child to the Citi Benefits Center through ConnectOne at **1-800-881-3938** within 31 days of the birth or adoption. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD and international assistance, please see the "For More Information" section.

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

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

You may designate or change your beneficiary for life insurance for your child at any time by calling MetLife at **1-888-830-7380** or visit the MetLife MyBenefits website available through TotalComp@Citi at **www.totalcomponline.com**.

Supplemental Accidental Death & Dismemberment (AD&D) insurance for you and your dependents

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

Enrolling in Supplemental AD&D coverage

You will enroll in coverage directly with MetLife, not through Citi. Visit the MetLife My Benefits site available through TotalComp@Citi at **www.totalcomponline.com**, or submit an enrollment form, which you can obtain by calling MetLife at **1-888-830-7380**.

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

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

Once you or your spouse/civil union partner/domestic partner have enrolled, your eligible children may be enrolled in Supplemental AD&D coverage in increments of $5,000 to a maximum of $20,000 at any time without evidence of insurability. Coverage for a child generally ends on the day the child reaches the maximum age of 27, or earlier if you lose eligibility for coverage.

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

Details about Accidental Death & Dismemberment (AD&D) insurance

Schedule of covered losses for employees

- Loss of life: 100% of the principal sum;
- Loss of any combination of hand, foot, or sight of one eye: 100% of the principal sum;
- Loss of an arm permanently severed at or above the elbow: 75% of the principal sum;
- Loss of a leg permanently severed at or above the knee: 75% of the principal sum;
- Loss of one hand or foot: 50% of the principal sum;
- Loss of all four fingers of the same hand: 25% of the principal sum;
- Loss of the thumb and index finger of same hand: 25% of the principal sum;
- Loss of all the toes of the same foot: 20% of the principal sum;
- Loss of sight of both eyes: 100% of the principal sum;
- Loss of sight in one eye: 50% of the principal sum;
- Loss of speech and hearing (in both ears): 100% of the principal sum;
- Loss of hearing (in both ears) or loss of speech: 50% of the principal sum;

- Quadriplegia: 100% of the principal sum;
- Paraplegia: 75% of the principal sum;
- Hemiplegia: 50% of the principal sum;
- Brain Damage; 100% of the principal sum;
- Coma: 1% monthly beginning on the 7th day of the Coma for the duration of the Coma to a maximum of 60 months.

Age reduction schedule

A covered person's principal sum will be reduced to the percentage of his/her principal sum in effect on the date preceding the first reduction, as shown below:

Age	Percentage of Benefit Amount
70 but less than 75	70%
75 but less than 80	45%
80 but less than 85	30%
85 or over	15%

Additional Basic AD&D benefits

Seatbelt and airbag benefit

- Seatbelt benefit: 10% of the principal sum subject to a maximum benefit of $25,000;
- Airbag benefit: 5% of the principal sum subject to a maximum benefit of $10,000.

Additional Supplemental AD&D benefits

Child care center benefit

If you die as a result of an accidental injury and MetLife pays a benefit, you will receive an additional Child Care benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that on the date of your death a child was enrolled in a Child Care Center; or within 12 months after the date of your death a child was enrolled in a Child Care Center.

A Child Care Center is a facility operated and licensed according to the law of the jurisdiction where it is located. The facility must provide care and supervision for children in a group setting on a regularly scheduled and daily basis.

Benefit Amount

For each child who qualifies for this benefit, MetLife will pay an amount equal to the Child Care Center charges incurred for a period of up to 4 consecutive years, not to exceed an annual maximum of $10,000; and an overall maximum of 5% of the Principle Sum.

MetLife will not pay for Child Care Center charges incurred after the date a child attains age 13.

MetLife may require proof of the child's continued enrollment in a Child Care Center during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit quarterly when MetLife receives proof that Child Care Center charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Child Education benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Child Education benefit if:

> This benefit is in effect on the date of the injury; and

> MetLife receives proof that on the date of your death a child was enrolled as a full-time student in an accredited college, university or vocational school above the 12th grade level; or at the 12th grade level and, within one year after the date of your death, enrolls as a full-time student in an accredited college, university or vocational school.

Benefit Amount

For each Child who qualifies for this benefit, MetLife will pay an amount equal to the tuition charges incurred for a period of up to four consecutive **academic years, not to exceed** an academic year maximum of $10,000; and an overall maximum of 20% of the Principle Sum.

MetLife may require proof of the child's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to the person who pays such charges on behalf of the child.

If this benefit is in effect on the date you die and there is no child who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Spouse education benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Spouse Education benefit if:

> This benefit is in effect on the date of the injury; and

> MetLife receives proof that on the date of your death, your spouse was enrolled as a full-time student in an accredited school; or within 3 years after the date of your death, your spouse enrolls as a full-time student in an accredited school.

Benefit Amount

MetLife will pay an amount equal to the tuition charges incurred for a period of up to one academic year, not to exceed an academic year maximum of $10,000; and an overall maximum of 3% of the Principle Sum.

MetLife may require proof of the spouse's continued enrollment as a full-time student during the period for which a benefit is claimed.

Benefit Payment

MetLife will pay this benefit semi-annually when MetLife receives proof that tuition charges have been paid. Payment will be made to your spouse. If this benefit is in effect on the date you die and there is no spouse who could qualify for it, MetLife will pay $1,000 to your beneficiary in one sum.

Hospital Confinement Benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Hospital Confinement benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that you or a dependent are confined in a hospital as a result of an accidental injury which is the direct result of such confinement independent of other causes.

Benefit Amount

MetLife will pay an amount for each full month of Hospital Confinement equal to the lesser of 1% of the Principle Sum and $2,500. MetLife will pay this benefit on a monthly basis beginning on the fifth day of confinement, for up to 12 months of continuous confinement. This benefit will be paid on a pro-rata basis for any partial month of confinement.

MetLife will only pay benefits for one period of continuous confinement for any accidental injury. That period will be the first period of confinement that qualifies for payment.

Benefit Payment

Benefit payments will be made monthly. Payment will be made to you. This additional benefit provides insurance only for accidents. It does not provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department.

Common Carrier Benefit

If you die as a result of an accidental injury and MetLife pays a benefit, MetLife will pay an additional Common Carrier benefit if:

- This benefit is in effect on the date of the injury; and
- MetLife receives proof that the injury resulting in the deceased's death occurred while traveling in a Common Carrier.

Benefit Amount

The Common Carrier Benefit is an amount equal to the Principle Sum.

Benefit Payment

For loss of your life, MetLife will pay benefits to your beneficiary. For a loss of a dependent's life, MetLife will pay benefits to you.

Exclusions

In addition to any benefit-specific exclusion, benefits will not be paid for any covered injury or covered loss that, directly or indirectly, in whole or in part, is caused by or results from any of the following unless coverage is specifically provided for by name in this document:

- Service in the armed forces or unit Auxiliary thereto;
- Aviation, other than a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline;
- War, whether declared or undeclared; or act of war, participation in a felony, riot, or insurrection
- Suicide or attempted suicide;
- Intentionally self-inflicted injury;
- Physical or mental illness or infirmity, or the diagnosis or treatment of such illness or infirmity;

- Infection, other than infection occurring in an external, accidental wound;
  - Loss caused by or contributed to by voluntary actions such as the voluntary intake or use by any means of:
    - Any drug, medication or sedative, unless it is taken or used as prescribed by a Physician or an "over the counter" drug, medication or sedative taken as directed;
    - Alcohol in combination with any drug, medication, or sedative; or
    - Poison, gas, or fumes;

MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Common disaster

If you and your spouse are injured in the same accident and die within 365 days as a result of injuries in such accident, the full amount that MetLife will pay for your spouse's loss of life will be increased to equal the full amount payable for your loss of life.

Continuing your Supplemental AD&D coverage once you lose eligibility

When you are no longer eligible for group coverage, you or your dependents can continue your Supplemental AD&D insurance by paying premiums directly to MetLife. Supplemental AD&D coverage continues through the last day of the month of your termination date.

After that, you'll receive a letter from MetLife describing your options for continuing your coverage. Your monthly premium may be significantly higher than the Citi employee rate.

Business Travel Accident/Medical (BTA/BTM) insurance

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

Coverage is provided by ACE American Insurance Company. All regular full-time and part-time employees have BTA coverage equal to five times their benefits eligible pay to a maximum benefit of $2 million. Your spouse (same or opposite sex)/civil union partner/domestic partner and/or dependent children are considered covered persons and have BTA coverage while accompanying you on a business or relocation trip paid for by the Company.

- An eligible spouse (same or opposite sex)/civil union partner/domestic partner has a coverage amount of $150,000.
- Each eligible dependent child (up to age 26) has a coverage amount of $25,000.

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

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

Your BTA beneficiary, the person or persons designated to receive any benefit payable at your death, is the same beneficiary designated for your Basic Life insurance. If you do not have Basic Life insurance, the beneficiary is your spouse/civil union partner/domestic partner, then your children, and then your estate.

Converting to an individual policy

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

Filing a claim for Basic Life, Basic Accidental Death & Dismemberment (AD&D), Group Universal Life (GUL), Supplemental AD&D, and Business Travel Accident/Medical (BTA/BTM) insurance

You must provide notice — either written, authorized electronic (i.e. fax, email), or telephonic notice of your claim — within 31 days after a covered loss occurs or begins or as soon as reasonably possible.

> For Basic Life, Basic AD&D, GUL, Supplemental AD&D and BTA/Medical insurance, you or your beneficiary may call the Citi Benefits Center. Call ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “pension, retiree health and welfare and survivor support” option. For TDD and international assistance, please see the “For More Information” section.

If proper notice, as indicated, is not given in that time, the claim will not be invalidated or reduced if it is shown that proper notice was given as soon as was reasonably possible.

Notice should include the insured’s name and policy number and the covered person’s name, address, policy and certificate number.

Survivor Support will send claim forms for filing proof of loss when it receives notice of a claim. The claimant must provide written or authorized electronic (i.e. fax, email) proof of loss, satisfactory to MetLife, within 90 days of the loss for which the claim is made. If Survivor Support does not send claim forms within 15 days after it receives notice of a potential claim (this may be longer if additional documentation is required), you or your beneficiary can submit — within 90 days — written or authorized electronic proof of the nature and extent of the loss for which the claim is made.

Failure of a claimant to cooperate in the administration of the claim may result in termination of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Long-Term Care (LTC) insurance

Effective January 1, 2012, no new participants will be permitted to enroll into the Citigroup Long-Term Care (LTC) Plan. Participants who enrolled on or before December 31, 2011 may continue to be participants under the LTC Plan.

If you enrolled in LTC coverage prior to January 1, 2012, premiums for you and your spouse/civil union partner/domestic partner will be deducted from your pay. You will pay for coverage with after-tax dollars; the cost is based on your age when you become insured. Family members who have enrolled for LTC coverage, other than spouses/civil union partners/domestic partners, are billed directly.

Family members who call to obtain information should provide your name as the Citi employee.

When LTC benefits are payable

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

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

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

You become eligible for benefits only upon confirmation of your qualifying condition by a care coordinator from John Hancock. The insured or the insured's representative must call the toll-free number to notify John Hancock of a potential claim, as soon as possible.

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

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

Benefits and services covered

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

Choosing a level of coverage

When you enrolled, you chose a daily maximum benefit (DMB) of a range of $115 to $405 a day from the table below. The DMB is the most the LTC Plan may pay for all covered services received on any day. Each DMB has a corresponding lifetime maximum benefit (LMB), which is the total amount payable for covered LTC services while you are insured for other than the stay-at-home benefit. Informal care is also subject to a calendar-year maximum.

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Nursing home DMB	$115	$175	$230	$290	$345	$405
Alternate care facility DMB[1]	$115	$175	$230	$290	$345	$405
Community-based professional care DMB[2]	$86.25	$131.25	$172.50	$217.50	$258.75	$303.75

	Option 1	Option 2	Option 3	Option 4	Option 5	Option 6
Informal care DMB	$28.75	$43.75	$57.50	$72.50	$86.25	$101.25
Informal care calendar-year maximum[3]	$862.50	$1,312.50	$1,725	$2,175	$2,587.50	$3,037.50
Lifetime maximum benefit (excluding stay-at-home benefit)	$209,875	$319,375	$419,750	$529,250	$629,625	$739,125
Stay-at-home lifetime maximum	$3,450	$5,250	$6,900	$8,700	$10,350	$12,150

[1] If you are a Kansas resident, the alternate care facility DMB benefit varies slightly. Call John Hancock at **1-800-222-6814** for details.

[2] Community-based professional care includes adult day care (Washington state refers to this as adult day health care) and the following services provided in your home: Home health care, hospice care, and homemaker services provided by a person certified or employed through a licensed home health care agency.

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

Stay-at-home benefit

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

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

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

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

Choosing a non-forfeiture LTC benefit or a contingent non-forfeiture LTC benefit

For an additional cost, you may have included a non-forfeiture benefit (reduced lifetime maximum paid-up benefit) in your coverage at enrollment. If you did not elect this option, the contingent non-forfeiture benefit will be included in your coverage at no additional cost.

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

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

The contingent non-forfeiture benefit can be exercised only in the event of a substantial premium increase. The contingent non-forfeiture benefit allows you to stop paying premiums and keep a reduced level of coverage.

If you exercise this benefit, you will keep your full DMB amount, but the LMB will be reduced. Your reduced LMB will equal the greater of the total amount of premiums paid for your insurance since your coverage was issued or 30 times the DMB. A substantial premium increase would range from 10% at issue-age 90 or older to 200% at issue-age 29 or younger as detailed in the certificate that you will receive if you are approved for coverage.

Choosing inflation protection: Automatic Benefit Increase (ABI) or future purchase option

You also had the option of including the ABI inflation protection provision at enrollment for an additional cost. If you do not elect this option, the future purchase option provision will be included in your coverage.

Under the ABI option, increases to your benefit amounts occur automatically each year. Each January 1, the DMB amount will be increased at an annual rate of 5% compounded. The LMB will be increased in proportion to the increase in the nursing home DMB. The benefit increase will continue to be made annually regardless of your age or whether you have met the benefit eligibility requirements under the policy. However, no future increases in benefit amount will apply if you stop paying premiums and continue coverage in effect on a reduced paid-up basis under the non-forfeiture benefit.

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

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

The LMB will be increased in proportion to the increase in the nursing home DMB. An inflation adjustment will not be available if you are issue-age 85 or older or if you have met the benefit eligibility requirements under the policy in the six months prior to the increase effective date or if your coverage is in reduced paid-up status. (If you are a resident of Connecticut, Delaware, Indiana, or Kansas, this provision varies slightly. Call John Hancock at **1-800-222-6814** for details.)

Additional features

Return of premium at death benefit

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

Age	Percentage of premium returned upon death
65 or younger	100%
66	90%
67	80%
68	70%
69	60%
70	50%

Age	Percentage of premium returned upon death
71	40%
72	30%
73	20%
74	10%
75 or older	0%

Waiver of premium

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

Portability

If you retire or leave Citi, you may continue coverage at group rates. You will pay premiums directly to John Hancock. Your insured family members may also continue their coverage as long as premiums are paid when due and benefits have not been exhausted. If the group policy is terminated and coverage is replaced by other group coverage, LTC coverage may be continued under the replacement plan or continued through John Hancock.

Bed reservation benefit

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

Alternate plan of care

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

Restoration of benefits

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

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

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

Coordination of benefits and exclusions

To prevent duplication of benefits, the LTC Plan contains a coordination of benefits provision that may reduce or eliminate the benefits otherwise payable under the LTC Plan when benefits are payable under another plan. (This provision does not apply to residents of Connecticut.)

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

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

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

Tax implications

The LTC Plan is funded through a group policy intended to be a qualified LTC insurance contract under Section 7702B(b) of the Internal Revenue Code.

Subject to specified dollar limits that vary depending on your age, you may be able to include your premium in your itemized deductions on your federal income tax return if your total medical expenses, including the allowable portion of your premium, exceed 7.5% of adjusted gross income, if you are age 65 or older. The allowable dollar limits are reviewed each year by the U.S. Treasury and adjusted accordingly. The benefits you receive under the policy generally are not considered taxable income. Consult your tax adviser if you have any questions or need details.

For more information

Contact John Hancock by calling the John Hancock Long-Term Care Insurance Department at **1-800-222-6814**.

Your family members who call should provide your name as the Citi employee.

Claims and Appeals

If you file a claim for benefits under the Life Insurance, Business Travel Accident/Medical, GUL, Supplemental AD&D, or the Long-Term Care Insurance Plans, your claim generally will be administered in accordance with the timetable outlined below. For additional details on the specific claims and appeals procedures, contact the applicable Claims Administrator.

Notice of adverse benefit determinations

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

> The specific reasons for the denial;

> The specific reference to the Plan documentation that supports these reasons;

- The additional information you must provide to perfect your claim and the reasons why that information is necessary;
- The procedure available for a further review of your claim, including a statement regarding your right to bring action under Section 502(a) of ERISA if your claim is denied on review; and
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request), if applicable.

Appeals

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

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

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

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

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

Notice of benefit determination on appeal

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

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

In the event that your appeal is denied, you have the right to bring a legal action under Section 502(a) of ERISA, provided that you file any lawsuit or similar enforcement proceeding, commenced in any forum, regarding the Plans within 12 consecutive months after the date of receiving a final determination on review of your claim or, if earlier, within two years from the date on which you were aware, or should have been aware, of the claim at issue in the suit.

The two-year limitation shall be increased by any time a claim or appeal on the issue is under consideration by the appropriate fiduciary. If any different period to begin suit is specified in an insurance contract forming part of the Plans or any shorter period is specified in the rules of the Claims Administrator, that period will apply to proceedings against the insurer or with regard to the ruling of that Claims Administrator, respectively.

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