Administrative information

This section contains general information about the administration of the Citi Plans, the Plan Sponsors, and Claims Administrators.

Contents

Your HIPAA rights

The Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for dependents.

Your special enrollment rights

If you decline to enroll in Citi medical coverage for you and/or your eligible dependents, including your spouse, because you and/or your family members have other health coverage, you may in the future be able to enroll yourself or your dependents in Citi coverage provided that you request enrollment within 31 days after the date your coverage ends because you or a family member lost eligibility under another plan or because COBRA coverage has ended.

In addition, if you have a new dependent as a result of a marriage, birth, or adoption or placement for adoption of a child, you may also be able to enroll yourself and your eligible dependents provided you call within 31 days after the marriage, birth, or adoption.

If you miss the 31-day deadline, you must wait until the next annual enrollment period — or have another qualified status change or special enrollment right — to enroll. Visit the “Qualified Changes in Status” section for more information.

To meet IRS regulations and plan requirements, Citi reserves the right at any time to request written documentation of any dependent’s eligibility for plan benefits and/or the effective date of the qualifying event.

Your right to privacy and information security

HIPAA requires employer health plans to maintain the privacy and security of your health information. HIPAA also requires the Citigroup Health Benefit Plan, Citigroup Dental Benefit Plan, Citigroup Vision Benefit Plan, Health Care Spending Account (HCSA), and Limited Purpose Health Care Spending Account (LPSA) (collectively, the Plans, individually the “Plan”) to provide you with a notice of the Plans’ legal duties and privacy practices with respect to your health information. The notice will describe how the Plans may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice will describe your rights with respect to your health information. Please refer to the “Notice of HIPAA Privacy Practices” on page 290 for more information. You can obtain a copy of the notice by contacting the Citi Benefits Center through 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.

Citigroup (the “Plan Sponsor”) shall use and disclose individually identifiable health information also known as Protected Health Information (“PHI”) as defined in 45 C.F.R. Parts 160 and 164, and specifically 45 C.F.R. sec. 164.504(f) (the “HIPAA Privacy Rule”), only to perform administrative functions on behalf of the Plans. The HIPAA Privacy Rule defines “PHI” to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, employer, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called “covered entities”), including a group health plan. The Plan Sponsor shall not use or disclose such information for any purpose other than as permitted to administer the Plans or as permitted by applicable law.

The Plans shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the Plan Documents have been amended to incorporate the provisions herein. The Plan Sponsor shall ensure that any agents, including subcontractors, to whom it provides PHI received from any of these Plans agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. The Plan Sponsor shall not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit Plan of the Plan Sponsor. The Plan Sponsor shall

report to the Plans any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for herein of which it becomes aware.

The Plans shall make PHI available to individuals in accordance with 45 C.F.R. sec. 164.524. The Plans shall make PHI available to these Plans for purposes of amending the Plans and shall incorporate any amendments to PHI in accordance with 45 C.F.R. sec. 164.526. The Plans shall make PHI available and any disclosures as required to provide an accounting of disclosures in accordance with 45 C.F.R. sec. 164.528.

The Plan Sponsor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plans with the HIPAA Privacy Rules; the Plan Sponsor shall notify the Plans of any such request by the Secretary prior to making such practices, book, and records available. The Plan Sponsor shall, if feasible, return or destroy all PHI received from the Plans that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purposes for which the disclosures were made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor shall ensure that only its employees or other persons within the Plan Sponsor's control that participate in administering the Plans shall be given access to PHI to be disclosed, including those employees or persons who receive PHI relating to Payment, Health Care Operations (as defined in the HIPAA Privacy Rules) of, or other matters pertaining to the Plans in the ordinary course of the Plan Sponsor's business and perform Plan administration functions. The Plan Sponsor agrees to demonstrate to the satisfaction of the Plans that it has put in place effective procedures to address any issues of noncompliance with the privacy rules described in this section by its employees or other persons within its control.

In addition, the Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of any Electronic PHI (as defined in the applicable HIPAA regulations) that it creates, receives, maintains or transmits on behalf of the Plans. The Plan Sponsor will also support the "firewall" described in the preceding paragraph with reasonable and appropriate security measures. The Plan Sponsor shall ensure that any agents or subcontractors to whom the Plan Sponsor supplies Electronic PHI agree to implement reasonable and appropriate security measures to protect such information. The Plan Sponsor shall report any Security Incident (as defined in the applicable HIPAA regulations) of which it becomes aware to the applicable plan.

Notice of HIPAA Privacy Practices

This Notice of Privacy Practices describes how the Citigroup Health Benefit Plan, Citigroup Dental Benefit Plan, Citigroup Vision Benefit Plan, Health Care Spending Account (HCSA), and Limited Purpose Health Care Spending Account (LPSA) (collectively referred to in this section as an "Organized Health Care Arrangement" and each individually referred to in this section as a "Component Plan") may use and disclose your PHI.

This notice also sets out Component Plans' legal obligations concerning your PHI and describes your rights to access and control your PHI. All Component Plans have agreed to abide by the terms of this notice. This notice has been drafted in accordance with the HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy Rule, contained in the Code of Federal Regulations at 45 CFR Parts 160 and 164 as amended by Title XIII, Subtitle D of the American Recovery and Reinvestment Act of 2009 (ARRA, P.L. 111-5) and regulations promulgated thereunder. Terms that are not defined in this notice have the same meaning as they have in the HIPAA Privacy Rule, as amended and its related regulations.

For answers to your questions and for additional information

If you have any questions or want additional information about this notice, call the Citi Benefits Center through 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. To exercise any of the rights described in this notice, contact the third-party administrator for the relevant Component Plan as instructed under "Contact information" on page 295.

Component Plans' responsibilities

Each Component Plan is required by law to maintain the privacy of your PHI. The HIPAA Privacy Rule defines "PHI" to include any individually identifiable health information (1) that is created or received by a health care provider, health plan, employer, insurance company, or health care clearinghouse; (2) that relates to the past, present, or future physical or mental health or condition of such individual; the provision of health care to such individual; or payment for such provision of health care; and (3) that is in the possession or control of an entity covered by the HIPAA Privacy Rule (called "covered entities"), including a group health plan. The Component Plans were required to limit the use, disclosure, or request for PHI to the extent practicable to either limited data sets or, if needed, the minimum necessary to accomplish the intended purpose of the use, disclosure, or request.

Component Plans are obligated to provide to you a copy of this notice setting forth their legal duties and privacy practices regarding your PHI. Component Plans must abide by the terms of this notice. If any of the Component Plans use or disclose PHI for underwriting purposes, the Component Plan will not use or disclose PHI that is your genetic information for such purposes.

Uses and disclosures of protected health information

The following describes when any Component Plan is permitted or required to use or disclose your PHI. This list is mandated by the HIPAA Privacy Rule.

Payment and health care operations

Each Component Plan has the right to use and disclose your PHI for all activities included within the definitions of "payment" and "health care operations" as defined in the HIPAA Privacy Rule, as amended by ARRA.

Payment: Component Plans will use or disclose your PHI to fulfill their responsibilities for coverage and provide benefits as established under their governing documents. For example, Component Plans may disclose your PHI when a provider requests information about your eligibility for benefits under a Component Plan, or it may use your information to determine if a treatment that you received was medically necessary.

Health care operations: Component Plans will use or disclose your PHI to fulfill Component Plans' business functions. These functions include, but are not limited to, quality assessment and improvement, reviewing provider performance, licensing, business planning, and business development. For example, a Component Plan may use or disclose your PHI (1) to provide information about a disease management program to you; (2) to respond to a customer service inquiry from you; (3) in connection with fraud and abuse detection and compliance programs; or (4) to survey you concerning how effectively such Component Plan is providing services, among other issues.

Business associates: Each Component Plan may enter into contracts with service providers — called business associates — to perform various functions on its behalf. For example, Component Plans may contract with a service provider to perform the administrative functions necessary to pay your medical claims. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose PHI but only after such Component Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your information.

Organized health care arrangement: Component Plans may share your PHI with each other to carry out payment and health care activities.

Other covered entities: Component Plans may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with certain health care operations. For example, Component Plans may disclose your PHI to a health care provider when needed by the provider to render treatment to you. Component Plans may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing, or credentialing.

Component Plans may also disclose or share your PHI with other health care programs or insurance carriers (including, for example, Medicare or a private insurance carrier, etc.) to coordinate benefits if you or your family members have other health insurance or coverage.

Required by law: Component Plans may use or disclose your PHI to the extent required by federal, state, or local law.

Public health activities: Each Component Plan may use or disclose your PHI for public health activities permitted or required by law. For example, each Component Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. Component Plans may also disclose PHI, if directed by a public health authority, to a foreign government agency collaborating with the public health authority.

Health oversight activities: Component Plans may disclose your PHI to a health oversight agency for activities authorized by law. For example, these oversight activities may include audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs, and government agencies that ensure compliance with civil rights laws.

Lawsuits and other legal proceedings: Component Plans may disclose your PHI in the course of any judicial or administrative proceeding or in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized in the court order). If certain conditions are met, Component Plans may also disclose your PHI in response to a subpoena, a discovery request, or other lawful process.

Abuse or neglect: Component Plans may disclose your PHI to a government authority authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, if a Component Plan believes you have been a victim of abuse, neglect, or domestic violence, it may disclose your PHI to a government entity authorized to receive such information.

Law enforcement: Under certain conditions, Component Plans may also disclose your PHI to law enforcement officials for law enforcement purposes. These law enforcement purposes include, for example, (1) responding to a court order or similar process; (2) as necessary to locate or identify a suspect, fugitive, material witness, or missing person; or (3) as relating to the victim of a crime.

Coroners, medical examiners, and funeral directors: Component Plans may disclose PHI to a coroner or medical examiner when necessary to identify a deceased person or determine a cause of death. Component Plans may also disclose PHI to funeral directors as necessary to carry out their duties.

Organ and tissue donation: Component Plans may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

Research: Component Plans may disclose your PHI to researchers when (1) their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI or (2) the research involves a limited data set that includes no unique identifiers, such as name, address, Social Security number, etc.

To prevent a serious threat to health or safety: Consistent with applicable laws, Component Plans may disclose your PHI if disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. Component Plans may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military: Under certain conditions, Component Plans may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, Component Plans may disclose, in certain circumstances, your PHI to the foreign military authority.

National security and protective services: Component Plans may disclose your PHI to authorized federal officials for conducting national security and intelligence activities and for the protection of the President, other authorized persons, or heads of state.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, Component Plans may disclose your PHI to the correctional institution or to a law enforcement official for (1) the institution to provide health care to you; (2) your health and safety and the health and safety of others; or (3) the safety and security of the correctional institution.

Workers' Compensation: Component Plans may disclose your PHI to comply with Workers' Compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

Disclosures to the Plan sponsor: Component Plans (or their respective health insurance issuers or HMOs) may disclose your PHI to Citi and its employees and representatives in the capacity of the sponsor of the Component Plans.

Others involved in your health care: Component Plans may disclose your PHI to a friend or family member involved in your health care, unless you object or request a restriction (in accordance with the process described in "Right to request a restriction" under "Your rights" on page 294. Component Plans may also disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then, using professional judgment, Component Plans may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: Each Component Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining a Component Plan's compliance with the HIPAA Privacy Rule.

Disclosures to you: Each Component Plan is required to disclose to you or to your personal representative most of your PHI when you request access to this information. Component Plans will disclose your PHI to an individual who has been designated by you as your personal representative and who is qualified for such designation in accordance with relevant law.

Prior to such a disclosure, however, each Component Plan must be given written documentation that supports and establishes the basis for the personal representation. A Component Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or such Component Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Other uses and disclosures of your protected health information

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization as provided to each Component Plan. If you provide such authorization to a Component Plan, you may revoke the authorization in writing, and such revocation will be effective for future uses and disclosures of PHI upon receipt. However, the revocation will not be effective for information that such Component Plan has used or disclosed in reliance on the authorization.

Contacting you

Each Component Plan (or its health insurance issuers, HMOs, or third-party administrators) may contact you about treatment alternatives or other health benefits or services that might be of interest to you, as permitted as part of health care operations, as defined in the HIPAA privacy rules.

As required by law, in the event of an unauthorized disclosure, use, or access of your unsecured PHI, you will receive written notification.

Your rights

The following is a description of your rights regarding your PHI. If you wish to exercise any of these rights, you must contact the third-party administrator of the Component Plan that you wish to have comply with your request, using the contact information in “Contact information” on page 295.

Right to request a restriction: You have the right to request a restriction on the PHI that a Component Plan uses or discloses about you for payment or health care operations. You also have a right to request a limit on disclosures of your PHI to family members or friends involved in your care or the payment for your care. You may request such a restriction using the contact information as instructed under “Contact information” on page 295.

A Component Plan is not required to agree to any restriction that you request. If a Component Plan agrees to the restriction, it can stop complying with the restriction upon providing notice to you. Your request must include the PHI you wish to limit; whether you want to limit such Component Plan’s use, disclosure, or both; and (if applicable) to whom you want the limitations to apply (for example, disclosures to your spouse).

A health care provider must comply with your request that PHI regarding a specific health care item or service not be disclosed to the Component Plan for purposes of payment and health care operations if you have paid for the item or service in full out of pocket.

Right to request confidential communications: If you believe that a disclosure of all or part of your PHI may endanger you, you may request that a Component Plan communicate with you in an alternative manner or at an alternative location. For example, you may ask that all communications be sent to your work address. You may request a confidential communication using the contact information in “Contact information” on page 295.

Your request must specify the alternative means or location for communicating with you. It also must state that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger. A Component Plan will accommodate a request for confidential communications that is reasonable and states that the disclosure of all or part of your PHI could endanger you.

Right to request access: You have the right to inspect and copy PHI that may be used to make decisions about your benefits. You must submit your request in writing. If you request copies, the relevant Component Plan may charge you for photocopying your PHI, and, if you request that copies be mailed to you, for postage. The third-party administrators of the Component Plans have indicated that they do not currently intend to charge for this service, although they reserve the right to do so.

You may request an electronic copy of your PHI if it is maintained in an electronic health record. In addition, you may request a copy of all electronic PHI maintained in a designated record set in the electronic form and format (e.g., web portal, e-mail or on portable electronic media) in which you and the Component Plan can reach an agreement that such information will be provided. You may also request that such electronic PHI be sent to another entity or person. Any charge that is assessed, if any, must be reasonable and based on the Component Plan’s cost.

Note: Under federal law, you may not inspect or copy the following records: Psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and PHI subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some, but not all, circumstances, you may have a right to have this decision reviewed.

Right to request an amendment: You have the right to request an amendment of your PHI held by a Component Plan if you believe that information is incorrect or incomplete. If you request an amendment of your PHI, your request must be submitted in writing, using the contact information in “Contact information” on page 295, and must set forth a reason(s) to support the proposed amendment. In certain cases, a Component Plan may deny your request for an amendment.

For example, a Component Plan may deny your request if the information you want to amend is accurate and complete or was not created by such Component Plan. If a Component Plan denies your request, you

have the right to file a statement of disagreement. Your statement of disagreement will be linked with the disputed PHI, and all future disclosures of the disputed information by such Component Plan will include your statement.

Right to request an accounting: You have the right to request an accounting of certain disclosures Component Plans have made of your PHI. You may request an accounting using the contact information in "Contact information" on page 295. You can request an accounting of disclosures made up to six years prior to the date of your request, except that Component Plans are not required to account for disclosures made prior to April 14, 2003.

You are entitled to one accounting from each Component Plan free of charge during a 12-month period. There may be a charge to cover a Component Plan's costs for any additional requests within that 12-month period. Component Plans will notify you of the cost involved, and you may choose to withdraw or modify your request before any costs are incurred.

Right to a paper copy of this notice: You have the right to a paper copy of this notice, even if you have agreed to accept this notice electronically. To obtain such a copy, call the Citi Benefits Center. See "Contact information" on page 295.

Complaints

If you believe a Component Plan has violated your privacy rights or is not fulfilling its obligation under the breach notice rules, you may complain to such Component Plan or to the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with such Component Plan using the contact information under "Contact information" on page 295. Component Plans will not penalize you for filing a complaint.

Changes to this notice

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

Effective date

This Notice of HIPAA Privacy Practices became effective April 14, 2003 and was revised effective August 14, 2013.

Contact information

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

Citi Privacy Officer
c/o Global Benefits Department
1 Court Square, 21st Floor
Long Island City, NY 11120

To exercise any of the rights described in this notice, contact the third-party administrators for the Component Plans as follows:

If you are enrolled in any of these Plans:	Call:
Citigroup Health Benefit Plan* **Citigroup Dental Benefit Plan** **Citigroup Vision Benefit Plan** **Health Care Spending Account** **Limited Purpose Health Care Spending Account** ***Note:** If you are enrolled in an HMO, call your HMO.	The Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative. **From outside the United States, Puerto Rico, and Canada:** Call **1-888-809-8455**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option and speak to a Citi Benefits Center representative. **For TDD users** Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Important notices about your Citi prescription drug coverage and Medicare

Citi has determined that prescription drug coverage provided through the medical options it offers is "creditable" under Medicare. See "For more information about Medicare" under "Creditable Coverage Disclosure Notice".

Creditable Coverage Disclosure Notice

For employees and former employees enrolled in Citi medical plan

This notice, required by Medicare to be delivered to Medicare-eligible individuals,* contains information about your current prescription drug coverage with Citi and prescription drug coverage available since January 1, 2006, to people with Medicare.

Keep this notice. If you enroll in Medicare prescription drug coverage, you may be asked to present this notice to prove that you had "creditable coverage" and, therefore, are not required to pay a higher premium than the premiums generally charged by the Medicare Part D Plans. You may receive this notice at other times in the future, for example, before the next period in which you can enroll in Medicare prescription drug coverage and/or if your Citi prescription drug coverage changes such that the coverage ceases to be "creditable coverage." You may request another copy of this notice by calling the Citi Benefits Center through 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.

* Citi is required by law to distribute this notice to both current employees and former employees who are enrolled in Citi coverage and who may be Medicare eligible. Generally, you become eligible for Medicare at age 65 or as a result of a disability as determined by the Social Security Administration.

Prescription drug coverage and Medicare

Effective January 1, 2006, prescription drug coverage through Medicare prescription drug plans became available to everyone with Medicare. This coverage is offered by private health insurance companies, not directly by the federal government. *All Medicare prescription drug plans provide at least a "standard" level of coverage set by Medicare.* Some plans might also offer more coverage for a higher monthly premium.

‘Creditable coverage’

You have prescription drug coverage through the Citigroup Health Benefit Plan. Citi has determined that your Citi prescription drug coverage is “creditable coverage” because, on average for all Plan participants, Citi prescription drug coverage is expected to pay in benefits at least as much as the standard Medicare prescription drug coverage will pay. Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Understanding the basics

It is up to you to decide what prescription drug coverage option makes the most financial sense for you and your family given your personal situation. If you are considering the option of joining a Medicare prescription drug plan available in your area, you need to carefully evaluate what that plan has to offer vs. the coverage you have through your Citigroup Health Benefit Plan. Before you decide to join a Medicare prescription drug plan, be sure you understand the implications of doing so,

- You *have* prescription drug coverage under your current Citigroup Health Benefit Plan. Your prescription drug coverage under the Citigroup Health Benefit Plan is considered primary to Medicare, if you are a current employee of Citi. This means that your Citi Plan pays benefits first. Although you can choose to join a Medicare prescription drug plan in addition to your enrollment in the Citigroup Health Benefit Plan, you should consider how Citi coverage would affect the benefits you receive under the Medicare prescription drug plan.
- If you drop your Citi prescription drug coverage and enroll in a Medicare prescription drug plan, you may not be able to get your Citi coverage back at a later date. You should compare your current coverage carefully — including which drugs are covered — with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
- Your existing Citi coverage is, on average, *at least as good* as standard Medicare prescription drug coverage (this is your “creditable” coverage). As a result, you can keep your current Citi coverage and *not* pay extra if you decide you want to join a Medicare prescription drug plan. People can enroll in a Medicare prescription drug plan when they first become eligible for Medicare. In addition, people with Medicare have the opportunity to enroll in a Medicare prescription drug plan during an annual enrollment period from October 15-December 7 for coverage effective the first day of the following year.
- If you drop or lose your coverage with Citi and do not immediately enroll in a Medicare prescription drug plan after your current coverage ends, you may pay more to enroll in a Medicare prescription drug plan later. If you lose your prescription drug coverage under the Citigroup Health Benefit Plan, through no fault of your own, you will be eligible for a 60-day Special Enrollment Period (SEP) to enroll in a Medicare prescription drug plan.

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

For more information about Medicare

More detailed information about Medicare Plans that offer prescription drug coverage is in the "Medicare & You" handbook (available at www.medicare.gov). Each year Medicare will mail a copy of the handbook to Medicare-eligible individuals. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare drug coverage, in addition to the "Medicare & You" handbook:

> Visit **www.medicare.gov**.

> Call your State Health Insurance Assistance Program (See your copy of the "Medicare & You" handbook for the telephone number).

> Call 1-800-MEDICARE (**1-800-633-4227**); for TDD users, call **1-877-486-2048**.

Your income may affect your Medicare premium

Some people may have to pay an extra amount because of their yearly income. If you have to pay an extra amount, Social Security—not your Medicare plan—will send a letter telling you what the extra amount will be and how to pay it. The extra amount will be withheld from your Social Security or Office of Personnel Management benefit check. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. If you have any questions about this extra amount, contact Social Security at **1-800-772-1213** between 7 a.m. and 7 p.m., Monday through Friday. TDD users should call **1-800-325-0778**.

Do you qualify for extra help from Medicare based on your income and resources?

You can obtain Medicare's income level and asset guidelines by calling 1-800-MEDICARE (**1-800-633-4227**). If you qualify for assistance, visit the Social Security website at **www.socialsecurity.gov** or call **1-800-772-1213** to request an application.

For more information about this notice

Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option.

For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.

Note: You will receive this notice each year, before the next period you can join a Medicare prescription drug plan, and if this coverage through Citi changes. You may also request a copy by calling the Citi Benefits Center as instructed immediately above.

ERISA information

As a participant in Citi Health and Welfare Plans subject to ERISA (which excludes HSA, DCSA and TRIP), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

You may examine all documents governing the Plans (including group insurance policies, where applicable) and copies of all documents filed with the U.S. Department of Labor (and available at the Public Disclosure Room of the Employee Benefits Security Administration) such as annual reports (Form 5500 Series). Upon written request to the Plan Administrator, you may obtain copies of documents governing the operation of the Plans, including insurance contracts, a copy of the latest annual report (Form 5500), and the current summary plan description. The Plan Administrator will mail these documents to your home free of charge. You may also receive a copy of the Plan's annual financial report. The Plan Administrator will furnish each participant with a copy of the Summary Annual Report.

If there is a loss of medical coverage as a result of a qualifying event, you may continue health care coverage for yourself, spouse (same- or opposite-gender/civil union partner/domestic partner, or eligible dependents. You or your dependents may have to pay for such coverage. Review this Plan/SPD and all other documents governing the Plans for the rules governing your continuation coverage rights.

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

If your claim for a benefit is denied, in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plans review and reconsider your claim and provide you with copies of documents relating to the decision without charge. For more information see “Claims and appeals” on page 303.

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

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

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

Answers to your questions

If you have questions about the Plan(s), contact the Plan Administrator listed under “Plan administration” on page 311.

If you have any questions about this Handbook or your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave. NW, Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications’ hotline of the Employee Benefits Security Administration or by visiting its website at **www.dol.gov/ebsa**.

Recovery provisions

Refund of overpayments

Whenever payments have been made by any of the Citigroup Health and Welfare Plans for covered or non-covered expenses in a total amount, at any time, in excess of the maximum amount payable under the Plan’s provision (“Overpayment”), the person(s) receiving benefits under the Plan(s) (the “Covered Person(s)”) must refund to the Plan(s) the applicable Overpayment and help the Plan(s) obtain the refund of

the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In the case of a recovery from a source other than the Plan(s), Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan(s) that should have been made under another group plan. In that case, the Plan(s) may recover the payment from one or more of the following: Any other insurance company, any other organization, or any person to or for whom payment was made.

The Plan(s) may, at their option, recover the Overpayment by reducing or offsetting against any future benefits payable to the Covered Person or his/her survivors; stopping future benefit payments that would otherwise be due under the Plan(s) (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the Covered Person.

The Plan Administrator of the Citigroup Disability Plan reserves the right to recover funds related to disability benefits for any Overpayment when a Covered Person receives state benefits including Workers' Compensation and Social Security benefits.

Reimbursement for Citigroup Health Benefit Plan

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

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

If the Covered Person receives payment from a third party or his or her insurance company as a result of an injury or harm due to the conduct of another party and the Covered Person has received benefits from the Plan, the Plan must be reimbursed first. In other words, the Covered Person's recovery from a third party may not compensate the Covered Person fully for all the financial expenses incurred because acceptance of benefits from the Plan constitutes an agreement to reimburse the Plan for any benefits the Covered Person receives.

The Covered Person also must take any reasonably necessary action to protect the Plan's subrogation and reimbursement right. That means by accepting benefits from the Plan, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

The Covered Person also must cooperate with the Plan Administrator's reasonable requests concerning the Plan's subrogation and reimbursement rights and must keep the Plan Administrator informed of any important developments in his or her action. The Covered Person also agrees that the Plan Administrator may withhold any future benefits paid by the Plan to the extent necessary to reimburse the Plan under the Plan's subrogation or reimbursement rights.

To secure the rights of the Plan under this section, the Covered Person hereby:

> Grants to the Plan a first-priority lien against the proceeds of any such settlement, verdict, or other amounts received by the Covered Person to the extent of all benefits provided in an effort to make the Plan whole;

- Assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage; the Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits; and
- Will cooperate with the Plan and its agents and will:
  - Sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement;
  - Provide any relevant information; and
  - Take such actions as the Plan or its agents reasonably request to assist the Plan in making a full recovery of the value of the benefits provided.

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

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

For information on the Plan's funding status visit the "Plan information" section.

Subrogation

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

The Plan is subrogated to all the rights of the Covered Person against any party, including any insurance carrier, liable for the Covered Person's injury or illness or for the payment for the medical treatment of such injury or occupational illness to the extent of the value of the medical benefits provided to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.

The Covered Person is obligated to cooperate with the Plan and its agents to protect the Plan's subrogation rights. Cooperation means complying with the terms of this section, providing the Plan or its agents with relevant information requested by them; signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim; responding to requests for information; appearing at requested medical examinations or depositions; and obtaining the consent of the Plan or its agents before releasing any party from liability for payment.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. Further, the Covered Person agrees to notify the Plan Administrator if and when the Covered Person institutes a lawsuit or other action or enters into settlement negotiations with another party (including his or her insurance company) in connection with or related to the conduct of another party.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties to the extent of benefits the Plan has provided for a sickness or injury caused by a third party. The Plan may, at its own option, take necessary and appropriate action to assert its rights under this section, including filing suit in your name, which does not obligate it in any way to pay you part of any recovery the Plan might obtain. The Plan's rights will not be reduced due to your own negligence.

The costs of legal representation retained by the Plan in matters related to subrogation shall be borne solely by the Plan. If the Plan incurs attorney's fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. The costs of legal representation retained by the Covered Person shall be borne solely by the Covered Person.

The Plan has the sole authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

For information on the Plan's funding status visit the" "Plan Information" section.

Aetna ChoicePlan 500 and Aetna HDHP only:

In addition to the above, the following also applies:

The Plan also has a right of subrogation. The Plan is subrogated to all the rights of the Covered Person against any party, including any insurance carrier, liable for the Covered Person's injury or illness or for the payment for the medical treatment of such injury or occupational illness to the extent of the value of the medical benefits provided to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that if he/she receives any payment from any Third Party as a result of an injury, illness or condition, he/she will serve as a constructive trustee over the funds that constitute such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the Plan.

The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition for which Third Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment or otherwise, including from any Insurance Coverage, related to treatment for any illness, injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, the Covered Person; the Covered Person's representative or agent; Third Party; Third Party's insurer, representative or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Third Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the Plan provided or purports to allocate any portion of such settlement or judgment to the payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person acknowledges that the Plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the Plan before any other claim for the Covered Person's damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any Third Party's payments, even if such payment to the Plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained.

The Covered Person acknowledges that the Plan has the right to conduct an investigation regarding the injury, illness or condition to identify any Third Party. The Plan reserves the right to notify Third Party and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the Plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him/her by reason of his/her present or future domicile.

For information on the Plan's funding status visit the "Plan information" section.

Qualified Medical Child Support Orders (QMCSOs)

As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a participant under a Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or the Health Care Spending Account/Limited Purpose Health Care Spending Account (HCSA/LPSA) who is an alternate recipient under a QMCSO will be considered as having a right to dependent coverage under the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan or the Health Care Spending Account/Limited Purpose Health Care Spending Account (HCSA/LPSA).

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

To receive, at no cost, a detailed description of the procedures for a QMCSO, or if you have a question about filing a QMCSO, call the Citi Benefits Center through 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.

You can file your QMCSO by mailing it to:

Attention: QMCSO Team
P.O. Box 1542
Lincolnshire, IL 60069-1542

Phone: **1-800-881-3938**, "health and welfare benefits" option
Fax: **1-847-442-0899**

Claims and appeals

Claims must be submitted in order to receive reimbursement for charges you incur when you seek care under the Plans. Many times, claims are submitted electronically to the Claims Administrator without your intervention needed. However, you may be required to manually submit claims for expenses to be paid or approved for reimbursement. For example, if you see an out-of-network physician, you will be required to manually submit a claim. 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" on page 315.

To file an eligibility or enrollment-related claim or appeal, for example, if enrollment in Citi Health and Insurance benefits has been denied in whole or in part, see "Eligibility and enrollment claims" on page 309 .

All claims for benefits must be filed within certain time limits for reimbursement.

- Medical, dental, and vision claims must be filed within two years of the date of service.
- Prescription drug claims must be filed within one year of the date of service.
- HCSA/LPSA/DCSA claims must be filed and resolved by June 30 of the calendar year following the Plan year in which the expense was incurred.
- TRIP parking cash reimbursement option claims must be filed within 12 months from the date of service.

How to file a claim	
Medical	
> For the ChoicePlan 500, Oxford PPO and High Deductible Health Plan (HDHP) (non-HMOs)	Use one of the following forms, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**, to file a claim for a covered out-of-network expense: > Aetna claim form (for ChoicePlan 500 and HDHP participants) > Anthem BlueCross BlueShield claim form (for ChoicePlan 500 and HDHP participants) > Oxford Health Plan claim form
> HMO participants	> Call your HMO for any claim-filing information.
Prescription Drugs	
> Express Scripts (prescription drug program related to all non-HMO medical plans including the ChoicePlan 500, HDHP, and Oxford Health Plan)	Use one of the following forms, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**, to file a claim for a covered out-of-network expense or home delivery: > Express Scripts Retail Pharmacy claim form > Express Scripts Home Delivery
Dental	
> MetLife Preferred Dentist Program (PDP)	> MetLife Dental claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**.
> Cigna Dental Care DHMO	> There are no claim forms to file under this Plan.
Vision	
> Aetna Vision	> Aetna Vision Plan claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**. > Call the Aetna Vision Plan at **1-877-787-5354**.
Employee Assistance Program	
	> Call Harris Rothenberg at **1-800-952-1245** or visit **www.harrisrothenberg.net** User ID: resources Password: for_you
Health Care Spending Account (HCSA) and Limited Purpose Health Care Spending Account (LPSA)	
	> If you do not use a Your Spending Account™ (YSA™) card for an eligible HCSA purchase, or if you are participating in an LPSA, you can file a claim by using the Health Care Spending Account/Limited Purpose Health Care Spending Account claim form, available in the Claim Forms section of Citi Benefits Online at **www.citibenefitsonline.com**, or submit a claim online via the YSA™ website. You may access the YSA™ website through a link on the Your Benefits Resources™ (YBR™) website. You can access YBR™ through TotalComp@Citi at **www.totalcomponline.com**, available from the Citi intranet and the Internet.
Dependent Day Care Spending Account (DCSA)	
	> DCSA Reimbursement Request Form, available in the Claim Forms section of Citi Benefits Online at **www.citibenefitsonline.com**.

How to file a claim	
Transportation Reimbursement Incentive Program (TRIP)	
> For TRIP parking participants enrolled in the Cash Reimbursement Option **only**	> Transportation Reimbursement Incentive Program (TRIP) claim form, available in the Find forms section of Citi Benefits Online at **www.citibenefitsonline.com**. **For TRIP parking participants enrolled in the Cash Reimbursement Option only.**
Short-Term Disability (STD)	
	> 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. For TDD and international assistance, please see the "For More Information" section.
Basic Life and Basic AD&D insurance	
	> To file a claim, your beneficiary may call the Citi Benefits Center 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.
GUL and Supplemental AD&D insurance	
	> To file a claim, your beneficiary may call the Citi Benefits Center 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.

To file a claim or appeal, you must use the designated form in accordance with the applicable Citigroup Health and Welfare Plan procedures. By participating in the Citigroup Health and Welfare Plans, you and your beneficiaries agree that you cannot commence a legal action against any of the Citigroup Health and Welfare Plans more than one year after your final appeal has been denied, unless an insurance contract made available under the Plan provides for a different limitation. No legal action can be brought to recover benefits under any of the Plans until the appeal rights described below have been exercised, and the Plan benefits requested in such appeal have been denied.

If you do not receive a benefit to which you believe you are entitled under any Citigroup Health and Welfare Plans subject to ERISA, which excludes HSA, DCSA and TRIP, or if your application for benefits is denied, in whole or in part, you may file a claim with the Plan Administrator or Claims Administrators, as applicable. For more information about the Plan Administrator and Claims Administrators, see "Plan administration" on page 311 and the list of Claims Administrators under "Claims Administrators" on page 315.

Please note that the health savings account ("HSA") associated with the HDHP benefit options is an account owned by each participant who establishes an HSA. The Citi HSA is not a plan and is designed to be exempt from ERISA.

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

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

Detailed procedures governing claims for benefits, applicable time limits, and remedies available under the Citigroup Health Benefit Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan, the Health Care Spending Accounts (HCSA/LPSA) and the Citigroup Disability Plan for the redress of denied claims are included in this Handbook.

Medical care claims

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

1. **Pre-service claim:** A claim is a pre-service claim if the receipt of the benefit is conditioned, in whole or in part, on receiving approval in advance of obtaining the medical care, unless the claim involves urgent care, as defined below. Benefits under any Plan that require approval in advance are specifically noted as being subject to pre-service authorization (also called prior authorization).

2. **Urgent care claim:** A claim involving urgent care is any pre-service claim for medical care or treatment to which the application of the time periods that otherwise apply to pre-service claim could seriously jeopardize the claimant's life or health or ability to regain maximum function or would — in the opinion of a physician with knowledge of the claimant's medical condition — subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

   On receipt of a pre-service request, the Claims Administrator will determine whether it involves urgent care, provided that, if a physician with knowledge of the claimant's medical condition determines that a claim involves urgent care, the claim review shall be treated as an urgent care claim.

3. **Post-service claim:** A post-service claim is any claim for a benefit under this Plan that is not a pre-service claim or an urgent care claim.

4. **Concurrent care claim:** A concurrent care decision occurs when the Claims Administrator approves an ongoing course of treatment to be provided over a period of time or for a specified number of treatments. There are two types of concurrent care claims:

   (a) where reconsideration of the approval results in a reduction or termination of the initially approved period of time or number of treatments; and

   (b) where an extension is requested beyond the initially approved period of time or number of treatments.

Deciding initial medical benefit claims

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

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

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

The Claims Administrator will decide an initial urgent care claim as soon as possible, taking into account the medical urgencies but no later than 72 hours after receipt of the claim.

However, if a claim is a request to extend a concurrent care decision (defined above) involving urgent care and if the claim is made at least 24 hours prior to the end of the initially approved period of time or number of treatments, the claim will be decided within no more than 24 hours after the receipt of the claim. Any other request to extend a concurrent care decision will be decided in the otherwise applicable time frames for pre-service, urgent care, or post-service claims.

A decision by the Claims Administrator to reduce or terminate an initially approved course of treatment is an adverse benefit decision that may be appealed by the claimant, as explained below. Notification to the claimant of a decision to reduce or terminate an initially approved course of treatment shall be provided sufficiently in advance of the reduction or termination to allow you to appeal the adverse decision and receive a decision on review under these procedures prior to the reduction or termination.

An initial post-service claim shall be decided within a reasonable time but no later than 30 days after the receipt of the claim.

Despite the specified time frames, nothing prevents you from voluntarily agreeing to extend the above time frames. In addition, if the Claims Administrator is not able to decide a pre-service or post-service claim within the above time frames due to matters beyond its control, one 15-day extension of the applicable time frame is permitted, provided that you are notified in writing prior to the expiration of the initial time frame applicable to the claim. The extension notice shall include a description of the matter beyond the Plan's control that justifies the extension and the date by which a decision is expected. No extension is permitted for urgent care claims.

If any information needed to process a claim is missing, the claim shall be treated as an incomplete claim.

If an urgent care claim is incomplete, the Claims Administrator shall notify you as soon as possible but no later than 24 hours following receipt of the incomplete claim. The notification may be made orally, unless you request a written notice, and it shall describe the information necessary to complete the claim and shall specify a reasonable time, no less than 48 hours, within which the claim must be completed. The Claims Administrator shall decide the claim as soon as possible but not later than 48 hours after the earlier of (a) receipt of the specified information or (b) the end of the period of time provided to submit the specified information.

If a pre-service or post-service claim is incomplete, the Claims Administrator may deny the claim or may take an extension of time, as described above. If the Claims Administrator takes an extension of time, the extension notice shall include a description of the missing information and shall specify a time frame, no less than 45 days, in which the necessary information must be provided. The time frame for deciding the claim shall be suspended from the date the extension notice is received by the claimant until the date the missing necessary information is provided to the Claims Administrator. If the requested information is provided, the Plan shall decide the claim within the extended period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

Notification of initial benefit decision by Plan

You will receive written notification of an adverse decision on a claim, and it 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;
- A statement disclosing any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse decision (or a statement that such information will be provided free of charge upon request);

- If the decision involves scientific or clinical judgment, disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical circumstances or (b) a statement that such explanation will be provided at no charge upon request; and
- In the case of an urgent care claim, an explanation of the expedited review methods available for such claims.

Written notification of the decision on a pre-service or urgent care claim will be provided to you whether or not the decision is adverse. Notification of an adverse decision on an urgent care claim may be provided orally, but written notification will be furnished no later than three days after the oral notice.

Appeals

You have the right to appeal an adverse decision under these claims procedures. The appeal of an adverse benefit decision must be filed within 180 days following your receipt of the notification of adverse benefit decision, except that the appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Claims and appeals” on page 303) must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate.

Failure to comply with this important deadline may cause you to forfeit any rights to any further review of an adverse decision under these procedures or in a court of law.

The appeal shall be decided within a reasonable time appropriate to the medical circumstances but no later than 30 days after receipt and all required information to conduct the review of the appeal.

The appeal of an urgent care claim shall be decided as soon as possible, taking into account the medical urgency but no later than 72 hours after receipt of the appeal.

The appeal of a post-service claim shall be decided within a reasonable period but no later than 60 days (30 days for Anthem) after receipt of the appeal.

The appeal of a decision to reduce or terminate an initially approved course of treatment (see the definition of concurrent care decision under “Claims and appeals” on page 303) shall be decided before the proposed reduction or termination takes place. The appeal of a denied request to extend a concurrent care decision shall be decided in the appeal time frame for a pre-service, urgent care, or post-service claim described above, as appropriate to the request.

Notice of benefit determination on appeal

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

- 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 and a statement of your right to bring an action under Section 502(a) of ERISA;
- 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 on request; and
- If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

External appeals

- The external appeals process is different for each medical benefit option provided under the Plan. For details on the external appeals process as it relates to the benefit option you are enrolled in, visit the Medical and Prescription drug sections.

Eligibility and enrollment claims

If you believe your application to enroll in or change any of the health and insurance plans subject to ERISA was incorrectly denied, you may file a claim with the Plans Administration Committee of Citigroup Inc. (the "Committee") to have your case reviewed. You may also file an appeal if the Committee denies your claim.

To file an eligibility or enrollment-related claim and for information on the claim review process, follow the instructions below. Use the Citigroup Employee Benefits Eligibility Claims and Appeals Form, available to you at no cost by calling the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the "health and welfare benefits" option. You can speak with a representative from 8 a.m. to 8 p.m. ET Monday through Friday, excluding holidays. For TDD and international assistance, please see the "For More Information" section. Follow the instructions on the form and return the form to the Committee:

Plans Administration Committee of Citigroup Inc.
c/o Claims and Appeals Management Team
P.O. Box 1407
Lincolnshire, IL 60069-1407

Fax: **1-847-554-1653**

All Other Benefit Claims

In addition, if you file a claim for benefits under the Citigroup Disability, 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.

Regarding appeals

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal would not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information;
- The Claims Administrator is required to give the participant notice of any internal rules, guidelines, protocols or similar criteria used as a basis for the adverse determination;
- You cannot file suit in federal court until you have exhausted these appeals procedures. However, you have the right to file suit under ERISA Section 502 following an adverse appeal decision;
- Each participant has the right to request and obtain documents, records and other information as it pertains to the Plan(s). Notwithstanding any provision of the Plan(s) to the contrary, you must file any lawsuit related to your adverse benefit determination within 12 consecutive months after the date of receiving such a determination 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(s), that period will apply to suits against the insurer.

Future of the Plans and Plan amendments

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

Citigroup Inc. (or its affiliate, if appropriate) has the right to amend, modify, suspend, or terminate any Plan, policy, or program in whole or in part, at any time, for any reason. Plan amendments shall be adopted and executed by the Senior Human Resources Officer of Citigroup Inc., a Committee of the Board of Directors of Citigroup Inc., or any officer of Citigroup Inc. authorized to adopt plan amendments or sign other documents on behalf of Citigroup Inc., and may include amendments to insurance contracts or administrative agreements.

In the event of the dissolution, merger, consolidation, or reorganization of Citigroup, the Plans will be terminated unless the Plans are continued by a successor to Citigroup. If a benefit is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to Citigroup to the extent permitted under applicable law.

Plan administration

The Plan Administrator, the Plans Administration Committee of Citigroup Inc., is responsible for the general administration of the Plans and has the full discretionary authority and power to control and manage all the administrative aspects of the Plans, except to the extent such authority has been delegated to the Claims Administrator.

In accordance with such delegation, the Plan Administrator and the Claims Administrator have the full discretionary authority to construe and interpret the provisions of the Plans and make factual determinations regarding all aspects of the Plans and their benefits including the power and discretion to determine the rights or eligibility of employees and any other persons and the amounts of their benefits under the Plans and to remedy ambiguities, inconsistencies, or omissions. Such determinations shall be binding on all parties.

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

- To administer and manage the Plans, including the processing and payment of claims under the Plans and the related recordkeeping, according to the terms of an administrative services or claims administration agreement;
- To prepare, report, file, and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency or to prepare and disclose to employees or other persons entitled to benefits under the Plans; and
- To act as Claims Administrator and to review claims and claim denials under the Plans to the extent an insurer or administrator is not empowered with such responsibility.

The delegation by the Plan Administrator may (but is not required to) be in writing.

The Plan Administrator will administer the Plans on a reasonable and non-discriminatory basis and shall apply uniform rules to all persons similarly situated. Except to the extent superseded by laws of the United States, the laws of New York will control in all matters relating to the Plans.

Compliance with law

The Plans shall be construed and administered in compliance with federal and state law mandates governing the Plans, including ERISA, COBRA, USERRA (Uniformed Services Employment and Re-employment Rights Act), HIPAA, the Code, the Mental Health Parity Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Women's Health and Cancer Rights Act of 1998, and the Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010.

Compliance with Section 125 of the Internal Revenue Code

This Handbook describing the Citigroup Health Plan, the Citigroup Dental Benefit Plan, the Citigroup Vision Benefit Plan and the applicable spending accounts under the Citigroup Spending Account Plan and documents governing participant elections generally are, when read together, intended to comply with the requirements of Section 125 of the Internal Revenue Code of 1986, as amended, and constitute a cafeteria plan. Eligible participants are authorized to make contributions to their HSAs under the cafeteria plan, pursuant to IRS guidance. All such documents are incorporated by reference to constitute a single plan, in accordance with applicable Treasury regulations.

As stated previously in this document, all participants are entitled to make their benefit elections under the foregoing Plans through salary reduction arrangements so that the participant's premium payments or health care spending account contributions can be made on a before tax basis.

This Handbook describes the benefits available, authorizes employees to enter into salary reduction arrangements to pay their portion of the health care premiums on a before tax basis and authorizes employees to contribute amounts under the Health Care Spending Account, Limited Purpose Health Care Spending Account, the Dependent Day Care Spending Account, and the Health Savings Accounts on a before tax basis with respect to subsequent expenses that will be incurred and later reimbursed.

Changes in such elections (except for the HSA) are available only in limited circumstances described in the Eligibility and Participation section. The change in coverage must be consistent with the change in status. For example, if a dependent is added, the coverage should increase (not decrease). In addition to the foregoing, the Plans permit election changes based on the special enrollment rights under HIPAA.

Pursuant to the Code and related guidance, eligibility requirements and contribution limits for the HSAs are determined on a monthly basis. As such, although HSA contributions can be made under a Section 125 cafeteria plan, HSA contributions are not subject to the change in status rule and participants are permitted to change their elections at any time. The HSA changes are effective as soon as administratively practicable.

Plan information

Item	Details
Plan sponsor	Citigroup Inc. 750 Washington Boulevard, 9th Floor Stamford, CT 06901
Employer Identification Number	52-1568099
Participating Employers	Citigroup Inc. and any of its U.S. subsidiaries in which at least an 80% interest is owned.
Plan Administrator	Plans Administration Committee of Citigroup Inc. c/o Claims and Appeals Management Team P.O. Box 1407 Lincolnshire, IL 60069-1407 Fax: **1-847-554-1653** **1-800-881-3938** (ConnectOne). From the ConnectOne main menu, choose the "health and welfare benefits" option and then speak to a Citi Benefits Center representative. Call **1-888-809-8455**. Press 1 when prompted. From the ConnectOne main menu, choose the "health and welfare benefits" option. For TDD users: Call the Telecommunications Relay Service at 711. Then call ConnectOne as instructed above.
Type of Administration	The Plans are administered by the Plans Administration Committee of Citigroup Inc. through agreements entered into with the Claim Administrators. However, final decision on the payment of claims rest with the Claim Administrators.
Agent for Service of Legal Process	General Counsel Citigroup Inc. 399 Park Avenue, 2nd Floor New York, NY 10043
Plan Year (for all Plans)	January 1 — December 31
Plan Names and Numbers	
Medical Plans (self-funded ChoicePlan 500, High Deductible Health Plan, and Oxford PPO) including prescription drugs; Health Savings Accounts (HSAs), and medical clinics	Citigroup Health Benefit Plan Plan number 508
Dental Plans (fully-insured MetLife PDP and Cigna DHMO)	Citigroup Dental Benefit Plan Plan number 505
Vision Plan (fully-insured Aetna Vision)	Citigroup Vision Benefit Plan Plan number 533
Health Care Spending Account/Limited Purpose Health Care Spending Account	Citigroup Flexible Benefits Plan Plan number 512

Item	Details
Employee Assistance Program	Citigroup Employee Assistance Program Plan number 521
Dependent Day Care Spending Account (DCSA)	Not applicable (DCSA is not subject to ERISA)
Transportation Reimbursement Incentive Program (TRIP)	Not applicable (TRIP is not subject to ERISA)
Basic Life, Basic AD&D, GUL, and Supplemental AD&D insurance	Citigroup Life Insurance Benefits Plan Plan number 506
Business Travel Accident/Medical insurance	Citigroup Business Travel Accident/Medical Plan Plan number 510
Long-Term Care insurance	Citigroup Long-Term Care Insurance Plan Plan number 535
Short-Term Disability and Long-Term Disability	Citigroup Disability Plan Plan number 530
For fully insured HMOs	Call the Citi Benefits Center at 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. Plan number 508
Funding	
> Medical Plan > Dental Plan	The Medical Plan and Dental Plan are funded through insurance contracts, the general assets of Citigroup, or a trust qualified under Section 501(c)(9) of the Code on behalf of the Plans. The cost of medical and dental coverage is shared by Citigroup and the participant. The following Plans are self-insured, and thus are not subject to state laws: > ChoicePlan 500 (administrated by Aetna and Anthem BlueCross BlueShield) > High Deductible Health Plan (administrated by Aetna and Anthem BlueCross BlueShield) > Oxford PPO The following Plans are fully-insured and are subject to state laws: > Health maintenance organizations (HMOs) > MetLife Preferred Dentist Program (MetLife PDP) > Cigna Dental HMO (dental health maintenance organization)
> Vision Plan > Employee Assistance Program > Health Care Spending Account (HCSA) > Limited Purpose Health Care Spending Account (LPSA)	The cost of the Vision Plan and medical spending accounts is provided by employee contributions. Citigroup pays for the Employee Assistance Program. The Vision Plan is funded through an insurance contract. The medical spending accounts and the Employee Assistance Program are funded from the general assets of Citigroup.
> Basic Life insurance > GUL insurance > Basic and Supplemental AD&D insurance > Business Travel Accident/Medical insurance	Basic Life, Basic AD&D, GUL, Supplemental AD&D, and Business Travel Accident/Medical insurance are fully-insured. Benefits are provided under insurance contracts between Citigroup and the Claims Administrator. The Claims Administrator, not Citigroup, is responsible for paying claims. Basic Life, Basic AD&D, and Business Travel Accident coverage is provided through employer contributions; GUL and Supplemental AD&D is provided through employee contributions.

Item	Details
> Disability Plan	STD benefits are paid from the general assets of the Company. STD coverage is provided by Citigroup; no employee contributions are required. A portion of the LTD benefits are fully insured and a portion of the benefits are paid from the general assets of the Company. The Claims Administrator, not Citigroup, is responsible for paying claims. LTD coverage is provided through both employer and employee contributions.
> Long-Term Care insurance (LTC)	LTC benefits are fully insured. The cost of LTC coverage is provided by employee contributions. Any refund, rebate, dividend adjustment, or other similar payment under any insurance contract entered into between Citigroup and any insurance provider shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse Citigroup for premiums it has paid or to reduce Plan expenses.

Claims Administrators

Each of the Claims Administrators below has the discretion and authority to render benefit determinations in a manner consistent with the terms and conditions of its respective Plan, namely, those provisions of the Plan Documents that apply to the participant and are administered by that particular Claims Administrator. Since TRIP, DCSAs and HSAs are not subject to ERISA, neither the Claims Administrator listed below nor the Plans Administration Committee is a fiduciary under ERISA for these arrangements.

Plan	Administrator contact information
Medical Plan And Prescription Drug Coverage	
ChoicePlan 500	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 **1-800-545-5862** Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 **1-855-593-8123** **Note:** Anthem does not underwrite or assume any financial risk for claims liability.
High Deductible Health Plan	Aetna Citigroup Claims Division P.O. Box 981106 El Paso, TX 79998-1106 **1-800-545-5862** Anthem BlueCross BlueShield P.O. Box 105187 Atlanta, GA 30348-5187 **1-855-593-8123**

Plan	Administrator contact information
Health Savings Account (HSA)	ConnectYourCare **1-888-846-6414** **www.connectyourcare.com**
Oxford Health Plans PPO	Oxford Health Plans, LLC P.O. Box 29139 Hot Springs, AR 71903 **1-800-396-1909** Appeals and Grievances Oxford Health Plans Issue Resolution Department P.O. Box 29135 Hot Springs, AR 71903 Oxford Grievance Review Board P.O. Box 29134 Hot Springs, AR 71903 Oxford Health Plans Clinical Appeals Department P.O. Box 29139 Hot Springs, AR 71903
For fully insured HMOs	Call the HMO directly at the telephone number on your ID card.
Prescription Drug Program	
Paper claims address	Express Scripts, Inc. P.O. Box 66583 St. Louis, MO 63166 **1-800-227-8338**
Home delivery service	Express Scripts Pharmacy P.O. Box 66566 St. Louis, MO 63166-6566 **1-800-227-8338**
Dental Plan	
MetLife Preferred Dentist Program (PDP)	Metropolitan Life Insurance Co. MetLife Dental Claims Unit P.O. Box 981282 El Paso TX 79998-1282 **1-888-830-7380** To submit an appeal: MetLife Group Claims Review P.O. Box 14589 Lexington, KY 40512-4093

Plan	Administrator contact information
Cigna Dental HMO	Cigna Dental HMO / Member Services 1571 Sawgrass Corporate Parkway Suite 140 Sunrise, FL 33323 **1-800-244-6224**
Vision	
Aetna Vision Plan	Aetna Vision Attn: OON Claims P.O. Box 8504 Mason, OH 45040-7111 **1-877-787-5354** **www.AetnaVisionOE.com/avp1** Members: **www.aetnavision.com**
Spending Accounts	
> Health Care Spending Account > Limited Purpose Health Care Spending Account > Dependent Day Care Spending Account > Transportation Reimbursement Incentive Program	Your Spending Account™ (YSA™/Plans Administration Committee of Citigroup Inc. [HCSA/LPSA]) P.O. Box 785040 Orlando, FL, 32828-5040 Call the Citi Benefits Center through ConnectOne at **1-800-881-3938**. From the ConnectOne main menu, choose the “health and welfare benefits” option and then the option for spending accounts, including transit and parking. For TDD and international assistance, please see the “For More Information” section.
Other Insurance	
Basic Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**
Basic and Supplemental Accidental Death and Dismemberment (AD&D)	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**
Business Travel Accident/Medical	ACE American Insurance Company Accident & Health Claims 1 Beaver Valley Road P.O. Box 15417 Wilmington, DE 19850 **1-800-336-0627**
Group Universal Life	Metropolitan Life Insurance Co. 200 Park Ave. New York, NY 10166 **1-800-638-6420**

Plan	Administrator contact information
Long-Term Care	John Hancock Life Insurance Company (U.S.A.) Group Long-Term Care, B-6 200 Berkeley St. Boston, MA 02117 **1-800-222-6814**
Short-Term Disability *Long-Term Disability*	Metropolitan Life Insurance Co. P.O. Box 14590 Lexington, KY 40511-4590 **1-888-830-7380**